Informed Consent to Telehealth and Remote Physiological Monitoring Services

I, hereby give my informed consent for medical treatment and procedures to be administered by the healthcare professionals at Cloud Health Medical Group, P.A., Cloud Health Medical Group of California, P.C., Cloud Health Medical Group of New Jersey, P.A. and Cloud Health Medical Group of Kansas, P.C. (collectively "**Cloud Health Medical**")**.** Cloud Health Medical provide remote monitoring services to patients ("RPM Services") using remote monitoring technologies ("**RPM Technology**"). By agreeing to this informed consent ("**Consent**"), you have elected to receive RPM Services via telehealth from Cloud Health Medical. If you have questions about use of the RPM Technology itself and whether it is appropriate for your medical condition, the risks associated with using the RPM Technology, or the provider's credentials and professional background, please ask your Cloud Health Medical provider. All capitalized terms used in this Consent but not defined herein will have the meanings provided in the Consent for Healthcare Services or Notice of Privacy Practices. Only use the Services if you have read this information and subsequently made an informed decision that the Services are right for you. If you have any questions, please email us at **legal@usebridge.com**.

I understand and acknowledge the following:

1. Nature of Consent:

I understand that by signing this form, I am authorizing Cloud Health Medical and its healthcare providers to provide medical treatment, conduct diagnostic tests, and perform necessary procedures to diagnose and treat my medical condition.

2. Nature of Treatment:

I acknowledge that Cloud Health Medical may employ a variety of medical treatments, including but not limited to examinations, diagnostic tests, medical procedures, surgeries, administration of medication, and the use of medical devices. I understand that alternative treatments, risks, and potential complications will be discussed with me before any procedures are performed.

3. Use of RPM Technology

I understand and agree that:

THE RPM TECHNOLOGY IS NOT AN EMERGENCY RESPONSE UNIT. YOU MUST CALL 911 FOR IMMEDIATE MEDICAL EMERGENCIES

a. Cloud Health Medical provider will decide, in his or her sole discretion, whether it is appropriate to treat your condition using the RPM Technology

b. I, or my Cloud Health Medical provider, may require an in-person examination prior to me receiving RPM services

c. The response time for electronic communications submitted through the RPM Technology varies and I accept any risk associated with the response time, including a delay in obtaining medical care

d. The RPM Technology provided to me is the property of Cloud Health Medical. I will not tamper with the RPM Technology and I understand that I am responsible for any costs and expenses related to the misuse of the RPM Technology

No warranty or guarantee has been made to me concerning any particular result related to my condition or diagnosis

4. Chronic Care Management (CCM) Services and Billing

I hereby consent to receive Chronic Care Management ("CCM") services from Cloud Health Medical Group as defined by the Centers for Medicare & Medicaid Services (CMS) under CPT codes 99490, 99439, 99487, 99489, and 99491, and as recognized by my health insurance plan.

I understand that CCM services involve the ongoing management of my chronic medical conditions under the direction of my healthcare provider and may include:

- At least 20 minutes of clinical staff time directed by a physician or qualified healthcare professional per calendar month;
- Non-face-to-face coordination and communication, including telephone calls, secure messaging, and review of medical data;
- Maintenance and regular review of a comprehensive electronic care plan; and
- Coordination with other healthcare professionals and community resources involved in my care.
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a. Acknowledgments and Authorizations

I acknowledge and understand that:

- CCM services are performed under the direction and general supervision of my treating provider at Cloud Health Medical Group.
- Only one provider may bill for CCM services for me during a given calendar month. By signing this consent, I authorize Cloud Health Medical Group to furnish and bill for these services until I revoke this consent.
- I may revoke this consent at any time by providing verbal or written notice to Cloud Health Medical Group. Revocation will be effective at the end of the month in which notice is received.
- Participation in CCM is voluntary, and refusal or withdrawal will not affect my eligibility for other medical care or services.
- CCM services may be subject to cost-sharing, including applicable copayments, coinsurance, or deductibles, as determined by my insurance plan (including Medicare and private/commercial insurers).

b. Billing and Privacy

I authorize Cloud Health Medical Group to bill Medicare and/or my private or commercial insurance for CCM services rendered. I agree to pay any patient-responsible amounts in accordance with my insurance benefits.

I understand that Cloud Health Medical Group and its clinical staff may use and disclose my protected health information (PHI) as necessary to provide, coordinate, and bill for CCM services in compliance with applicable HIPAA privacy and security regulations.

By signing below, I acknowledge that I have read and understand this consent form, that my participation is voluntary, and that I consent to receive and be billed for Chronic Care Management services as described above.

5. Principal Illness Navigation (PIN) and Community Health Integration (CHI) Services

I hereby consent to receive Principal Illness Navigation ("PIN") and/or Community Health Integration ("CHI") services from Cloud Health Medical Group as defined by the Centers for Medicare & Medicaid Services (CMS) and as recognized by my health insurance plan.

Principal Illness Navigation (PIN) - CPT 99484

I understand that PIN services are provided when I have been diagnosed with a single serious, high-risk disease that is the focus of a comprehensive care plan. PIN services may include:

- Assessment of my medical, functional, and psychosocial needs related to my principal illness;
- Establishment, implementation, revision, and/or monitoring of a person-centered care plan;
- Ongoing communication and care coordination between relevant practitioners furnishing care;
- At least 60 minutes of clinical staff time per calendar month, directed by a physician or other qualified healthcare professional, with the following required elements:
- Communication with me (or caregiver) regarding the care plan, coordination of care, and education and support;
- Communication with home health agencies and other community service providers utilized by me;
- Collection of health outcome data and registry documentation;
- Facilitation of access to care and services;
- Management of care transitions, including referrals;
- Medication reconciliation and management.

Community Health Integration (CHI) - CPT 99426, 99427, 99437

I understand that CHI services are designed to address my health-related social needs (such as food insecurity, housing instability, or transportation barriers) and may include:

- Systematic assessment of my social determinants of health (SDOH); Development and implementation of a plan to address identified health-related social needs;
- Facilitation of and/or provision of services to address health-related social needs;
- At least 20 minutes of clinical staff time per calendar month directed by a physician or other qualified healthcare professional (CPT 99426 for first hour, 99427 for each additional 30 minutes);
- For complex patients, integration with behavioral health and/or psychiatric collaborative care (CPT 99437).

If I receive Community Health Integration (CHI) services, I understand and consent to the following:

(i) Non-Medical Service Providers: CHI services may involve referring me to and coordinating with community-based organizations that are NOT healthcare providers, including:

- Food assistance programs and food banks
- Housing agencies and homeless services
- Transportation services
- Utility assistance programs
- Social service agencies
- Other community resources

(ii) Information Sharing: To facilitate these referrals and ensure I receive needed services, Cloud Health Medical Group may need to share relevant health information with these organizations, including:

- My name and contact information
- My health-related social needs (e.g., "patient needs food assistance")
- Medical information necessary to demonstrate eligibility for services
- Follow-up information about whether services were received

(iii) Privacy Limitations: These community organizations may NOT be covered by HIPAA and may have different privacy practices than healthcare providers. Cloud Health Medical Group will share only the minimum information necessary to connect me with services.

(iv) Right to Decline: I may decline any specific referral or information sharing with community organizations at any time without affecting my other medical care.

(v) Revocation: I may revoke this consent for CHI community information sharing by notifying Cloud Health Medical Group in writing or verbally, effective at the end of the calendar month.

(vi) Substance Use Disorder Treatment Information (42 CFR Part 2): If I am receiving treatment for substance use disorder, I understand that federal law (42 CFR Part 2) provides additional privacy protections for substance use disorder treatment records. For CHI services, if addressing my health-related social needs requires sharing information about my substance use disorder treatment with community organizations, I understand I may be asked to sign a separate consent form that meets 42 CFR Part 2 requirements before such information can be shared.

By signing below, I specifically authorize Cloud Health Medical Group to share my health information with community-based organizations as described above for the purpose of addressing my health-related social needs through CHI services.

a. Acknowledgments and Authorizations

I acknowledge and understand that:

- PIN and CHI services are performed by clinical staff under the direction of my treating physician or other qualified healthcare professional at Cloud Health Medical Group.

- Eligibility
    - For PIN services: I have a single serious, high-risk illness that is the focus of the care plan.
    - For CHI services: I have health-related social needs that affect my health outcomes.
- Billing limitations
    - Only one physician or qualified healthcare professional may bill for PIN services for me during a given calendar month
    - Only one physician or qualified healthcare professional may bill for CHI services for me during a given calendar month
    - By signing this consent, I authorize Cloud Health Medical Group to furnish and bill for these services until I revoke this consent
- Required Information
    - Only one practitioner can furnish and be paid for these services during a calendar month
    - I will be given a copy of this consent
    - The initiation of these services is voluntary and I can stop them at any time (effective at the end of the calendar month)
- I may revoke this consent at any time by providing written or verbal notice to Cloud Health Medical Group. Revocation will be effective at the end of the month in which notice is received.
- Participation in PIN and CHI services is voluntary, and refusal or withdrawal will not affect my eligibility for other medical care or services.
- PIN and CHI services may be subject to cost-sharing, including applicable copayments, coinsurance, or deductibles, as determined by my insurance plan.
- CHI services may involve coordination with community-based organizations to address my health-related social needs.

Important: PIN services typically cannot be billed in the same month as Chronic Care Management (CCM) or certain other care management services. CHI services (CPT 99426/99427) may be billed with other services if the time and activities are separate and distinct. RPM services may be billed with CCM, PIN, or CHI if they involve different physiological data and separate time. Your provider will determine which combination of services is appropriate and billable for you each month.

b. Billing and Privacy

I authorize Cloud Health Medical Group to bill Medicare and/or my private or commercial insurance for PIN and CHI services rendered. I agree to pay any patient-responsible amounts in accordance with my insurance benefits.

I understand that Cloud Health Medical Group and its clinical staff may use and disclose my protected health information (PHI) as necessary to provide, coordinate, and bill for PIN and CHI services in compliance with applicable HIPAA privacy and security regulations. For CHI services, this may include sharing relevant health-related social needs information with community-based organizations involved in addressing those needs.

By signing below, I acknowledge that I have been provided a copy of this consent, that I have read and understand this consent for PIN and CHI services, that my participation is voluntary, and that I consent to receive and be billed for these services as described above.

IMPORTANT: YOUR RIGHT TO STOP THESE SERVICES

You may stop CCM, PIN, and/or CHI services at any time by:

- Telling any Cloud Health Medical staff member (verbal), OR
- Sending written notice to: legal@usebridge.com

Your request will take effect at the end of the calendar month in which we receive it. Stopping these services will NOT affect your ability to receive other medical care.

If you wish to restart services later, you will need to sign a new consent form.

6. Telehealth:

Telehealth services involve interactive video conferencing equipment and devices that let my health care provider deliver health care services to me from a location that is different than my location. I confirm that I have read this form (or had it explained to me) and understand the following:

a. I will not be physically in the same room as my health care provider during the visit. I will be told about and asked for my consent before any other Cloud Health Medical staff or trainees actively assist my health care provider during this visit.
b. There are risks and consequences associated with telehealth services. These include, but are not limited to:
    i. disruption of the appointment caused by technology failures;
    ii. the limited ability of my health care provider to respond to emergencies during the visit;
    iii. interruption or violations of confidentiality by people who do not have permission to be at the visit. While Cloud Health Medical takes all reasonable steps to secure telehealth visits and breaches are very rare, no technology is completely secure; and
    iv. the chance that I or my health care provider decides that the video conferencing equipment or connection is not adequate for this visit and decides to stop the telemedicine visit, switch to an alternate Cloud Health Medical-approved video conferencing service, or make other arrangements to continue the visit;
    v. the chance that during a telehealth visit, my provider may not identify medical conditions that otherwise may be identified during an in-person visit.
c. I have the right to refuse to participate or stop participating in a telehealth visit, and my refusal will be written in my medical record. I understand that my refusal my impact my right to future care or treatment at Cloud Health Medical.
d. The laws that protect the privacy and confidentiality of my health care information apply to telehealth services.
e. My health care information may be shared with other individuals for scheduling and billing purposes.
    i. I understand that health plan payment policies for telehealth visits may be different from policies for in-person visits.
    ii. I understand that I am responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telehealth visit.
f. I understand that during the telehealth visit, I must be physically located in a state where my provider is licensed, or my provider will not be able to conduct the visit, and it will need to be rescheduled. If I am in a state other than the state I previously provided at the

time of my visit, I will tell the provider's office before the visit to confirm that they can see me.

g. I have had all my questions about this telehealth service answered to my satisfaction. The risks, benefits, and alternatives to telehealth visits have been shared with me in a language I understand.

7. Risks and Benefits:

I understand that all medical treatments and procedures carry certain risks and potential benefits. While Cloud Health Medical will take necessary precautions to minimize risks, I acknowledge that no guarantees or assurances can be made regarding the outcome of any treatment or procedure.

8. Risks Associated with Use of RPM Technology

I understand that use of the RPM Technology has risks associated with it, such as (1) information transmitted through the RPM Technology may be insufficient to allow for appropriate medical decision-making by Cloud Health Medical provider; (2) failures of equipment or infrastructure may cause delays in medical evaluation and treatment, or loss of information; and (3) unauthorized access to my medical information. I acknowledge that, although Cloud Health Medical and its RPM Technology vendor strive to prevent unauthorized access to information about me through encryption of information transmitted by the RPM Technology and other security measures, Cloud Health Medical and its vendor cannot guarantee that my use of the RPM Technology and the information will be private or secure, and I consent to this risk. I understand and consent to the risks associated with the use of the RPM Technology.

9. Privacy and Confidentiality:

I acknowledge that Cloud Health Medical is committed to protecting the privacy and confidentiality of my personal health information in accordance with applicable laws and regulations. I authorize the collection, use, and disclosure of my health information for the purposes of treatment, payment, and healthcare operations.

10. Financial Responsibility:

I understand that I am financially responsible for all medical services rendered by Cloud Health Medical. I agree to pay all charges for services not covered by my insurance, including deductibles, co-pays, and any outstanding balances.

11. Right to Refuse or Withdraw Consent:

I can refuse or withdraw my consent for medical treatment at any time. I understand that this decision may have consequences and that I should discuss any concerns or questions with my healthcare provider.

12. Communication and Follow-up:

I understand the importance of open and honest communication with my healthcare provider. I agree to provide accurate and complete information about my medical history, current medications, allergies, and other relevant details. I understand I should follow any post-treatment instructions and attend follow-up appointments as recommended.

13. Authorization for Medical Decision-Making:

I authorize Cloud Health Medical and its healthcare providers to make necessary medical decisions on my behalf if I cannot do so, based on their professional judgment and in accordance with applicable laws and regulations.

14. Choice of Pharmacy Services:

If you receive a prescription as a result of your use of the Services, you may choose to have your prescription fulfilled through the pharmacy of your choice. You give us consent to send and disclose to the pharmacy of your choice all information provided by you, health care records, and other applicable health care information and personal information (such as your name, location and demographic information) so that you may receive pharmacy services.

15. Additional Patient Consents:

a. If I am experiencing a medical emergency, I will be directed to dial 9-1-1 immediately and my Provider is not able to connect me directly to any local emergency services.
b. I may elect to seek services from a medical group or provider with in-person clinics as an alternative to receiving telehealth services.
c. I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time without affecting my right to future care or treatment.
d. Federal and state law requires health care providers to protect the privacy and the security of health information. I am entitled to all confidentiality protections under applicable federal and state laws. I understand all medical reports resulting from the telehealth visit are part of my medical record. Medical Group will take steps to make sure that my health information is protected in accordance with applicable laws.
e. Telehealth may involve electronic communication of my personal health information to other health practitioners who may be located in other areas, including out of state.
f. There is no guarantee that I will be treated by a Medical Group Provider. My Provider reserves the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of my Provider, the provision of the Services is not medically or ethically appropriate

Agreement and Consent:

I have read and understood the contents of this Medical Consent Form, and I voluntarily consent to receive medical treatment and procedures from Cloud Health Medical.

Additional State-Specific Consents and Disclosures.

The following consents apply to patients accessing Cloud Health Medical Group's services for the purposes of participating in a telehealth consultation as required by the states listed below:

Alaska: I understand that my primary care provider may obtain a copy of my records of my telehealth encounter. I have been informed that if I want to register a formal complaint about a provider, I should visit the medical board's website, here.

Arizona: I understand I am entitled to all existing confidentiality protections pursuant to A.R.S. § 12- 2292. I also understand all medical reports resulting from the RPM Services are part of my medical record as defined in A.R.S. § 12-2291. I also understand dissemination of any images or information identifiable to me for research or educational purposes shall not occur without my consent, unless authorized by state or federal law.

California: I understand that some or all of my CCM, PIN, and CHI services may be provided using telehealth technologies and may involve coordination with community-based organizations and social service agencies.

I consent to the sharing of my health information, including information about my social circumstances (such as housing, food security, and transportation needs), among Cloud Health Medical Group's affiliated entities, care team members, and community-based organizations for the purpose of coordinating my care and addressing my health-related social needs, consistent with the California Confidentiality of Medical Information Act (CMIA).

For CHI services, I understand that addressing my health-related social needs may require Cloud Health Medical Group to share relevant health information with non-medical community service providers (such as housing agencies, food banks, and transportation services). I consent to such disclosures when necessary to facilitate services that address my health-related social needs.

Colorado: I consent to the use of telehealth for my CCM, PIN, and CHI services. I understand that I will not be charged separately for the use of telehealth technology and that my privacy will be protected under Colorado law.

For CHI services, I consent to Cloud Health Medical Group sharing necessary health information with community service providers to address my health-related social needs.

Connecticut: I understand that my primary care provider may obtain a copy of my records, my RPM services and my telehealth encounter.

Florida: To view my rights under Florida's Patient Bill of Rights and Responsibilities, I should visit the Florida Agency for Health Care Administration or click here. To view my rights under Florida's Weight-Loss Consumer Bill of Rights, I should visit here.

I understand that my provider may not be physically located in Florida when telehealth CCM, PIN, or CHI services are provided. I consent to receive these services under Florida's Telehealth Practice Act.

For CHI services, I consent to coordination with community-based organizations to address health-related social needs affecting my health.

Georgia: I have been given clear, appropriate, accurate instructions on follow-up in the event of needed emergent care related to the RPM Services.

Hawaii: I consent to the use of telehealth for CCM, PIN and CHI services as permitted by Hawaii law. I understand that my privacy will be protected under state and federal law and that I may withdraw consent at any time.

For CHI services, I consent to coordination with community organizations to address my health-related social needs.

Idaho: I have been informed that if I want to register a formal complaint about a provider, I should visit the medical board's website, here.

Illinois: I understand that telehealth may be used for parts of my CCM, PIN, and CHI care. Participation is voluntary, and I may choose in-person visits when available.

For CHI services specifically, I understand that:

- Cloud Health Medical Group may coordinate with community-based organizations to address my health-related social needs
- This may involve sharing relevant health information with non-medical service providers (such as housing agencies, food programs, or transportation services)
- Such information sharing is necessary to connect me with resources that support my health and wellbeing
- I may decline to participate in community referrals at any time

I consent to telehealth and community coordination consistent with Illinois law, including the Telehealth Act (225 ILCS 150).

Indiana: I have been informed that if I want to register a formal complaint about a provider, I should visit the medical board's website, here.

Iowa: I have been informed that if I want to register a formal complaint about a provider, I should visit the medical board's website, here.

Kansas: I understand that if I have a primary care provider or other treating physician, the person providing telemedicine, RPM, CCM, PIN, or CHI services must send a report to such primary care or other treating physician of the treatment and services rendered to me within three days of me providing consent to send such report.

Kentucky: I have been informed that if I want to register a formal complaint about a provider, I should visit the medical board's website, here.

Maine: I have been informed that if I want to register a formal complaint about a provider, I should visit the medical board's website, here; or, the Maine Board of Osteopathic Licensure's website, here.

New Jersey: I understand I have the right to request a copy of my medical information and I understand my medical information may be forwarded directly to my primary care provider or health care provider of record, or upon my request, to other health care providers.

I understand that some of my CCM, PIN, and CHI services may be delivered using telehealth. I have been informed of my provider's identity, credentials, and location, and I consent to receive telehealth services consistent with New Jersey law.

For CHI services specifically, I consent to Cloud Health Medical Group coordinating with community-based organizations to address my health-related social needs. This may include sharing relevant health information with social service providers (such as housing agencies, food assistance programs, or transportation services) to facilitate access to resources that support my health.

New Hampshire: I understand that my primary care provider or treating provider may obtain a copy of my records of my telehealth encounter.

New York: I consent to receive telehealth services as part of my Chronic Care Management, Principal Illness Navigation, and Community Health Integration services.

I understand that CHI services may involve sharing health information with community-based organizations and social service providers to address my health-related social needs (such as food insecurity, housing instability, or transportation barriers). I consent to such information sharing when necessary to coordinate services that support my health.

I understand that all communications will be secure and that my information will remain confidential under New York law, including New York Public Health Law Article 27-F.

Ohio: I understand that my primary care provider may obtain a copy of my records of my telehealth encounter.

Oklahoma: I have been informed that if I want to register a formal complaint about a provider, I should visit the medical board's website, here; or, the Oklahoma Board of Osteopathic Examiners' website, here.

Oregon: I consent to receive telehealth Chronic Care Management, Principal Illness Navigation, and Community Health Integration services under Oregon law.

For CHI services, I understand that:

- Addressing my health-related social needs may require coordination with community organizations
- This may include sharing relevant health information with non-medical service providers
- Such coordination follows all confidentiality rules applicable in Oregon

I consent to information sharing necessary to connect me with community resources that address my health-related social needs.

Rhode Island: If I use e-mail or text-based technology to communicate with my Perry Health provider, then I understand the types of transmissions that will be permitted and the circumstances when alternate forms of communication should be utilized. I have also discussed security measures, such as encryption of data, password protected screen savers and data files, or utilization of other reliable authentication techniques, as well as potential risks to privacy. I have been informed that if I want to register a formal complaint about a provider, I should visit the medical board's website, here.

South Carolina: I understand that my medical records may be distributed only with my consent and in accordance with applicable laws and regulations to other treating health care practitioners.

South Dakota: I have received disclosures regarding the RPM Services RPM Technology and limitations.

Texas: I understand that with my consent, medical records related to my CCM, PIN, and CHI services may be sent to my primary care physician within 72 hours after receiving services.

I consent to the use of telecommunication technology, including telephone or electronic communications, as part of my Chronic Care Management, Principal Illness Navigation, and Community Health Integration services.

For CHI services, I understand that addressing my health-related social needs may require coordination with community organizations and social service providers. I consent to Cloud Health Medical Group sharing necessary health information with such organizations to facilitate services (such as housing assistance, food resources, or transportation support) that address my health-related social needs.

I understand that these services will comply with Texas Medical Board telemedicine standards and that I may decline telehealth at any time.

I have also been informed of the following notice:

NOTICE CONCERNING COMPLAINTS -Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018, Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353, For more information, please visit www.tmb.state.tx.us.

AVISO SOBRE LAS QUEJAS- Las quejas sobre médicos, asi como sobre otros profesionales acreditados e inscritos del Consejo Médico de Tejas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugia, se pueden presentar en la siguiente dirección para ser investigadas: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018, Si necesita ayuda para presentar una queja, llame al: 1-800-201-9353, Para obtener más información, visite nuestro sitio web en www.tmb.state.tx.us.

Utah: I understand (i) any additional fees charged for RPM Services, if any, and how payment is to be made for those additional fees; (ii) to whom my health information may be disclosed and for what purpose, and have received information on any consent governing release of my patient-identifiable information to a third-party; (iii) my rights with respect to patient health information; (iv) appropriate uses and limitations of the RPM Technology, including emergency health situations. I understand that the RPM Services Cloud Health Medical provides meets industry security and privacy standards, and comply with all laws referenced in the Utah regulations. I was warned of: potential risks to privacy notwithstanding the security measures and that information may be lost due to technical failures, and agree to hold Provider harmless

for such loss. I have been provided with the location of Cloud Health Medical's website and contact information. I am able to a (i) access, supplement, and amend my patient-provided personal health information; and (ii) obtain upon request an electronic or hard copy of my medical record documenting the RPM Services, including the Consent provided; and (iii) request a transfer to another provider of my medical record documenting the telemedicine services.

For CHI services, I understand that addressing my health-related social needs may require sharing information with community-based organizations. I have been informed about (i) which types of organizations my information may be shared with; (ii) the purpose of such sharing; (iii) my rights regarding this information; and (iv) potential privacy limitations when information is shared with non-HIPAA covered entities.

Virginia: I acknowledge that I have received details on security measures taken with the use of RPM Technology, as well as potential risks to privacy notwithstanding such measures. I agree to hold harmless Cloud Health Medical for information lost due to technical failures; and I provide my express consent to forward patient-identifiable information to a third party.

I consent to the use of telemedicine for my CCM, PIN, and CHI services, consistent with Virginia law. I understand that telehealth services will be conducted securely and documented in my record.

For CHI services, I specifically consent to Cloud Health Medical Group sharing my patient-identifiable information with community-based organizations and social service providers when necessary to address my health-related social needs and coordinate access to community resources.

Vermont: I understand that I have the right to receive a consult with a distant-site provider and will receive one upon request immediately or within a reasonable time after the results of the initial consult. I understand that receiving telemedicine services via Found's Platform does not preclude me from receiving real-time telemedicine or face-to-face services with the distant provider at a future date.

I have been informed that if I want to register a formal complaint about a provider, I should visit the Vermont Board of Medical Practice website, here or the Vermont Board of Osteopathic Examiners, here.

Washington: I consent to receive telemedicine as part of my Chronic Care Management, Principal Illness Navigation, and Community Health Integration services.

For CHI services, I understand that addressing my health-related social needs may require Cloud Health Medical Group to:

- Share my health information with community-based organizations and social service providers
- Coordinate referrals to housing, food, transportation, and other support services
- Follow up with community partners to ensure services are received

I consent to such information sharing and coordination when necessary to address my health-related social needs. I understand that this consent will be recorded in my medical record, and that all services will meet Washington privacy and security requirements.

Washington D.C.: I consent to receive telehealth services as part of my Chronic Care Management, Principal Illness Navigation, and Community Health Integration services.

I understand that my provider may not be located in the District of Columbia at the time of service, and that all telehealth interactions will comply with D.C. telemedicine standards.

For CHI services, I consent to coordination with community-based organizations to address my health-related social needs, which may involve sharing relevant health information with social service providers.