AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION FROM BLOOM HEALTHCARE TO DESIGNATED INDIVIDUAL (INCLUDING PORTAL ACCESS)

Completion of this document authorizes the use and disclosure of health information about you. Failure to provide all information requested may invalidate this Authorization.

Patient Name:_____ DOB:_____

I hereby authorize Physician Housecalls, LLC d/b/a Bloom Healthcare ("Bloom Healthcare") 12600 West Colfax Avenue, Lakewood, CO 80215 to disclose to

Name: _____ (print name of Authorized Recipient)

Email: _____ Cell phone: _____

all my information received or maintained about me by or on behalf of Bloom Healthcare, including demographic information, financial information, and health information. The purpose of this disclosure is to permit the above-named Recipient to interact with Bloom Healthcare on my behalf, which I understand will including the Recipient accessing the information Bloom Healthcare receives or maintains about me.

This Authorization is valid until I am no longer eligible to receive services from Bloom Healthcare or for the duration permitted under applicable state law, whichever is earlier. I understand that, except to the extent that a lawful holder of my information has acted in reliance on this Authorization, I have the right to revoke this Authorization, in writing, at any time by sending a written revocation to Bloom Healthcare.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of such information and may no longer be protected by federal or state law. Bloom Healthcare will not condition my treatment or services on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to: inspect or copy the information to be used or disclosed as permitted under federal or state law; refuse to sign this Authorization; and receive a copy of this Authorization. I have read the above information and authorize the disclosure of my information by Bloom Healthcare for the purpose described herein.

By signing below, I acknowledge that I have read and agree to the terms of this Authorization.

_____ _____

Patient Signature* Date

*Please be aware that the **patient** is required to sign this document to designate an alternate individual who will be authorized to access the Bloom Health Patient Portal. If the patient is unable to sign this document (such as due to incapacity), kindly engage in a discussion with the Bloom staff for further guidance.