Information Release, Laboratory Billing Consent & HIPAA Acknowledgment

The Council of State Governments (CSG) has engaged Heed Medical, P.C. and Heed Health, LLC ("Heed") to coordinate testing for COVID-19 using PCR and/or rapid antigen tests. Heed clinicians will collect specimens from you during a site visit(s) or via remote testing methods. The processing of any COVID-19 PCR testing will subsequently be performed by a third-party laboratory (the "Laboratory"). CSG is making COVID-19 testing available for the purpose of screening for COVID-19 infections. The cost for the Laboratory to conduct COVID-19 PCR testing will be billed to your insurance, the cost of any Rapid Antigen Testing and Heed Services unrelated to lab processing fees will be paid for by CSG. For CSG to know the results of your COVID-19 PCR and/or Rapid Antigen Tests, your authorization is required. The purpose of this Assignment of Benefits and Release of Limited Medical Information form is for you to authorize the Laboratory to bill your insurance for lab services, and to authorize the release of your test results to CSG, and to consent to the collection of COVID-19 specimens while on-site at an upcoming CSG event.

ASSIGNMENT OF BENEFITS

I hereby assign to the Laboratory any monies and/or other benefits available for health care services provided to me from insurance carriers, HMOs or other entities financially liable to pay for my medical care and treatment. I agree to forward all health insurance payments that I receive for services rendered to me immediately upon receipt.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of Heed's Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Heed and how I may obtain access to and control this information.

ACKNOWLEDGEMENT OF ELECTRONIC RECEIPT OF RESULTS

When possible, results will be provided via secure patient portal. In the event that results via portal are not available, or if I have trouble accessing the portal, I understand that my results may be provided to me by phoneand/or by e-mail, which is not a secure method of communication.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has alreadybeen taken based on this authorization.

1. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a healthplan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
2. Information disclosed under this authorization might be redisclosed by the recipient, and thisredisclosure may no longer be protected by federal or state law.
3. This authorization does not authorize you to discuss my health information or medical care with anyoneother than the entity specified in item 6(a). This authorization also does not authorize disclosure of anyinformation that is specially-protected under state law.
4. Name and address of health providers or entities to release this information:
    a. **Heed Medical, P.C**, 52 Wooster Street Suite 2, New York, NY 10013
5. Name and address of person(s) or category of person to whom this information will be sent:
    a. The Council of State Governments
6. Specific information to be released:
    a. Medical record from HEED facilitated COVID-19 services, including the results of my COVID-19 medical test, symptom screenings and communications with a HEED provider
7. Reason for release of information: At request of individual
8. Date or event on which this authorization will expire: **One year after its effective date**.

Signature:_____ Date: _____