**EXHIBIT F**

**PATIENT AUTHORIZATION FOR PROVIDER'S ACCESS, USE AND DISCLOSURE OF RECORDS AND/OR PROTECTED HEALTH INFORMATION THROUGH JACKSON COMMUNITY MEDICAL RECORD, L3C**

**Grass Lake Medical Center** ("Provider") is participating in a community wide electronic health record system ("EHR System") established by Jackson Community Medical Record L3C ("JCMR") and has obtained a Sub-License to use the EHR Software. This means that my Provider will create an individual electronic health record for me in the JCMR EHR System which consists of my private health information ("PHI") which will be available electronically to my Provider and other healthcare Providers and their respective Permitted Users for purposes of providing healthcare services to me including treatment, payment and other healthcare operations. Examples of PHI include but are not limited to my name, address, insurance information, payment history, social security number, laboratory and other diagnostic test results or reports, medications, medical history, surgery information, immunization records and any notes kept by my Provider or the Provider's office related to my care. In order to create the EHR for me, my Provider and his Permitted Users will be required to disclose my PHI to JCMR, who operates and maintains the community wide EHR.

**CONSENT TO ACCESS, USE OR DISCLOSE OF PROTECTED HEALTH INFORMATION.**

I understand that it is the intent of Provider to hold all of my individually identifiable health information (medical information or "PHI") with the utmost level of confidentiality. I authorize and give consent to my Provider, his/her/its Permitted Users, to create and use an EHR which includes disclosing my PHI to JCMR and other healthcare Providers who provide me with healthcare services, for my continuing care and treatment, payment, healthcare operations, and as described in each Provider's Privacy Notice. This includes my consent and authorization for the release and disclosure of any medical information necessary to process insurance claim(s) on my behalf. I also authorize payment of medical health insurance benefits to be made directly to Provider and/or his/her/its designees for services rendered.

**AUTHORIZATION FOR ACCESS TO JCMR MEDICAL RECORD AND RELEASE OF INFORMATION.**

If a JCMR EHR has already been created for me, I consent and authorize Provider and his/her/its Permitted Users to access my JCMR EHR for my continuing care and treatment, payment or healthcare operations. This includes my consent and authorization for the release and disclosure of any medical information necessary to process insurance claim(s) on my behalf. I also authorize payment of medical health insurance benefits to be made directly to Provider and/or his/her/its designees for services rendered.

I have read this form in its entirety or have had it read to me. Additionally, I have had the opportunity to ask any questions that I may have and they have been answered to my satisfaction.

Patient Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date: _____

Printed Name and Address of Patient: _____

Patient Date of Birth_____