Authorization for Release of Group Health Insurance Claims and Related Health Information to VIGILANT HEALTH, INC., dba "THE CLINIC"

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Name of Covered Person / Clinic Patient (please print) **Date of Birth (MM/DD/YYYY)**

I, the above named Covered Person and Clinic Patient, authorize **The Southern Farm Bureau Life Insurance Company Comprehensive Major Medical Group Health Insurance Plan, which is a component of the Southern Farm Bureau Life Insurance Company Health and Welfare Benefits Plan, by and through the Plan's third-party administrator, UMR[SM] and the Plan's pharmacy benefits manager, CVS /Caremark™ (hereinafter referred to collectively as "The Plan")**, to release, share and disclose any health insurance claims information and related medical records that the Plan may have pertaining to me to **VIGILANT HEALTH, INC.,** its, employees, agents, and authorized representatives (also referred to as "The Clinic"). This includes, but is not limited to, major medical health insurance and medical claims information, claims history, diagnosis codes, treatment notes and related medical information about me to the extent available to the Plan, pertaining to any medical, psychiatric or psychological conditions; prescription drugs and pharmaceutical records; diagnostic testing; laboratory records; alcohol, tobacco or drug use, unless otherwise restricted by state law. This Authorization specifically excludes psychotherapy notes. I also acknowledge that any previous agreement I have made to restrict my protected health information as maintained by The Plan does not apply to this Authorization, and I authorize the Plan to release, share and disclose to VIGILIANT HEALTH, INC., my entire health insurance claims history and related medical records as maintained by the Plan without restriction.

The protected health information to be disclosed under this Authorization is given so that VIGILIANT HEALTH, INC., by and through The Clinic, may seek to improve the health of persons covered under the Plan, not just those who may access The Clinic, and for The Clinic to better coordinate your entire medical and claims information, to the extent you consent for the Plan to make your protected health information available to VIGILANT HEALTH, INC., and The Clinic. For example, VIGILANT HEALTH, INC., and The Clinic seek to access Plan information related to your medical claims history, diagnoses, treatment plans, prescription history, and compliance with prior wellness programs that you may have received from outside medical providers so that VIGILIANT HEALTH, INC., and The Clinic may assist you in taking a more active and efficient role in preventing, maintaining and/or improving your health beyond the medical treatment you receive from outside medical providers treating you under the Plan. To the extent you authorize VIGILIANT HEALTH, INC. and The Clinic to do so, VIGILIANT HEALTH, INC. and The Clinic will access claims information from the Plan about you to coordinate your medical care with your existing physicians and other providers, but will not attempt to replace any care and treatment you receive from your outside medical provider(s), which shall always remain your decision and as permitted by the Plan. Moreover, **the only persons who will receive your protected health and claims information under this Authorization are only those health professionals who provide your care and are part of The Clinic. Moreover, your employer will <u>not</u> have access to any protected health information shared about you pursuant to this Authorization, unless otherwise subject to exceptions already applicable to the Plan.** As a business associate of the Plan, any health information that is accessed, stored or transmitted electronically about you will also be kept confidential, encrypted and fully secured by VIGILENT HEALTH, INC., and The Clinic.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Vigilant Health, 576 Highland Colony Parkway, Suite 210G, Ridgeland, MS 39157, Attn: Privacy Officer. I understand that a revocation is not effective to the extent that VIGILANT HEALTH, INC. has relied on this Authorization, or to the extent that the Plan, via VIGILANT HEALTH, INC., has a legal right to access my information or contest a claim under the Plan. I understand that if I alter, revoke, or refuse to sign this Authorization to release my entire health insurance plan claims information and medical records, VIGILANT HEALTH, INC., may not be able to offer to me all treatment and services that might otherwise be available through The Clinic; however, **The Clinic will <u>not</u> condition treatment on whether or not I sign this Authorization**. I acknowledge by my signature below, that I have a right to receive, and have in fact received, a copy of this Authorization.

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Signature of Covered Person / Clinic Patient (*or Parent or Guardian*) **Date (MM/DD/YYYY)**

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Address of Covered Person / Clinic Patient, or their Guardian, if signing

(Rev. 5/17)

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Relationship to Covered Person / Clinic Patient (*if other than self*)