

By Checking this Box I authorize J-Med and/or associated employees/volunteers or associated entities to collect, use, and/or disclose pertinent Protected Health Information (PHI) about me including but not limited to individuals, healthcare organizations/entities, healthcare providers, pharmacies, any government agency necessary to complete the services sought by me, by any legitimate means including but not limited to email, fax, text, letter, audio communication or other physical or digital means. I agree to electronic health record recording and generation of documentation by digital means. I also acknowledge this authorization permits J-Med and/or associated entities to contact me by means as outlined above to notify me of pertinent information regarding my care, licenses, permits, promotions, etc. I acknowledge and understand the above and am making an informed decision to proceed to receive care by J-Med and/or associated entities. I understand that I have the right to refuse to sign/acknowledge this authorization, in which case will not be able to proceed making an appointment since the transmission of PHI is required to accomplish the purpose of delivery of care. I also understand that I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted in writing to J-Med and/or associated entities by E-mail to: neobodyrx@gmail.com