Dear Patients of McMinn Clinic, Inc.,

It has been my honor to serve as your physician, and I appreciate you trusting me with your health care needs. As you may already be aware, effective January 1, 2023, I will be retiring from the full-time practice of medicine and McMinn Clinic, Inc. (the "Practice") will be closing. After January 1, 2023, as a result of my retirement, I will no longer be available to provide medical treatment and other health care-related services to you.

If your condition requires further treatment, you will need to make alternate arrangements to place yourself under the care of a qualified health care provider. MedHelp, P.C. ("MedHelp") has agreed to take custody of the Practice's medical records and to be available to treat you should you desire to continue your treatment with one of MedHelp's providers. For more information on MedHelp, you may visit https://medhelpclinics.com/. If you are interested in making an appointment with a MedHelp provider after January 1, 2023, you may contact MedHelp's office at (205) 208-7646.

Following the Practice's closure, a copy of your medical records will be transferred to MedHelp, as custodian, and such records will be maintained by MedHelp and available to you for at least ten (10) years. If you choose to further your care with MedHelp, your records will be available to the MedHelp providers without any further action by you. If you choose to continue your care elsewhere, a copy of your medical records may be requested by you or your new provider at any time by contacting my office (if prior to January 1, 2023) at (205) 868-1313 or by contacting MedHelp (if after January 1, 2023) at (205) 208-7646. The enclosed HIPAA-compliant authorization form may be necessary in order to facilitate the transfer of your medical records to another provider.

If you have any questions or concerns regarding the continuation of your care and treatment following the closure of the Practice, please feel free to reach out to me before January 1, 2023 to discuss potential options based on your specific needs. I may be reached at (205) 868-1313.

I realize that a change in providers can be difficult, and I am committed to making this transition as smooth as possible. I appreciate you allowing me to treat you, and I extend my best wishes for your future health and happiness.

Sincerely,

James E. McMinn

James McMinn, M.D.
McMinn Clinic, Inc.

Enclosure (HIPAA Authorization Form)

Patient Authorization for Disclosure of Protected Health Information

Patient Name:	Date of Birth:
Address:	

I hereby authorize McMinn Clinic, Inc. and/or MedHelp, P.C., acting as custodian of the records for McMinn Clinic, Inc. (collectively, the "Practice"), to disclose the above-named patient's health information to the following:

Name: _____
Address: _____
_____
Phone: _____

Specific description of the health information to be disclosed (*include dates of service, i.e., appointment date, type of service, etc):* _____
_____

This health information is to be disclosed for the following purpose (*if Authorization requested by the patient put: "At the request of the individual"*): _____
_____

By providing this Authorization, I understand as follows:

1. **I understand that this Authorization may result in the sending of clinical information and x-rays with reference to the above-named patient's diagnosis and/or any alcohol, drug or child abuse problems, behavioral or mental health services, and/or information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). I understand that these records are strictly confidential and are solely for the information of the person to whom addressed.**

2. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and the above-named patient's treatment and/or payment obligations will not be affected unless either of the following applies:

   - The treatment is related to research and the use and/or disclosure is related to such research; or
   - The treatment is solely for the purpose of creating protected health information for disclosure to a third-party.

3. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by federal or state law.

4. I understand that this Authorization is continuous in nature and is to be given full force and effect, including disclosing and/or utilizing any and all of the foregoing information learned or determined after the date hereof but prior to the expiration date noticed below.

5. I understand that I may revoke this Authorization at any time by notifying the Practice in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. Unless otherwise revoked, this Authorization will expire in one (1) year.

6. I understand that, upon request, I may receive a copy of this Authorization form after I sign it.

7. I understand that a photocopy or facsimile of this Authorization shall be valid and effective, just as the original.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed Name of Patient's Representative (*if applicable*)

_____
Representative's Relationship to Patient (*if applicable*)