Medical Consent & Release Authorization

Please sign below to indicate your agreement to participate in WorldClinic's service.

CONSENT TO TRANSFER MEDICAL INFORMATION

On behalf of myself and my family members, I authorize WorldClinic®, Inc. and Physicians Telemedicine Group, PLLC., through their employees and representatives to transfer, share or discuss my personal medical records or condition to or with other medical providers or related personnel, as deemed medically necessary to preserve my health or treat any actual or suspected medical condition I may have. This limited consent does NOT authorize WorldClinic, Inc., Physicians Telemedicine Group, PLLC or their employees or personnel to transfer, share or discuss my medical records or condition with any other person without my consent.

CONSENT TO TELEMEDICINE SERVICE

On behalf of myself and my family members, I acknowledge that, the physicians of Physicians Telemedicine Group, PLLC and WorldClinic, Inc. will use every reasonable means at their disposal to assist in the appropriate diagnosis and treatment of medical problems experienced by me while I am abroad. I acknowledge that medical care through telecommunications is not a perfect substitute for an in -person visit with my physician and may be limited in both scope and capability. For this reason, I agree that the physicians of the Physicians Telemedicine Group, PLLC (and WorldClinic®, Inc. by association) shall not be subject to the same medical practice standards as those applied to physicians performing in -person consultations. I further acknowledge that I will provide accurate information to WorldClinic® doctors. I also acknowledge that I am free to decline any such services.

MEMBER AGREEMENT

On behalf of myself and my family members, I consent and agree to abide by all of the terms and conditions of the contract between WorldClinic®, Inc. and my employer (the "Member Agreement"). I acknowledge that I have had an adequate opportunity to review the terms and conditions of the Member Agreement prior to signing this Member Approval, understand its terms and conditions and agree that such terms and conditions shall exclusively govern the relationship between me and my family members, on the one hand, and WorldClinic®, Inc., Physicians Telemedicine Group, PLLC, their affiliates and subsidiaries, on the other hand.

MEDICAL RECORDS RELEASE AUTHORIZATION

On behalf of myself and any of my minor children, I hereby authorize the physician(s) named herein to furnish copies of my (our) medical records to:

Physicians Telemedicine Group, PLLC
276 Newport Road, Suite 205
New London, NH 03257
Tel: 603-526-9003 • 800-636-9186
Fax: 781-998-7954

Primary Care Physician Name: ____

City and State: ____

Physicians Phone: ____

I understand that this authorization is valid for one year from the date shown below and that a photocopy or FAX copy of this authorization shall be granted the same authority as the original, and that the recipient, Physicians Telemedicine Group, PLLC, is prohibited from disclosing this information to any other party without my express consent except in the event of and only to the extent necessary for, medical necessity or for the processing of insurance or other reimbursement claims.

Customer's signature: ______________________________ Date: ______________________

Print Name: ______________________________