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Highly Recommended	Probably		Maybe	Probably Not	Never
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Right Away	Less than		Between	Over 1 hour	Over 2 hours
	30 minutes		30 and 60 minutes		
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Signature:				D	ate: 8/22/15

Thank you! Your responses will be visible on ZocDoc until ZocDoc elects to remove them or you revoke your authorization. To leave another review, please book your next appointment online at www.zocdoc.com.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

This is an important document. Please read carefully and only sign if you feel comfortable doing so.
You are a patient of Mohammad M. Alam (your "Physician") at Family Medical Group"). Our Medical Group is listed on a physician-searching website, called ZocDoc. Patients, such as you, can use ZocDoc to find doctors and schedule appointments. ZocDoc encourages physicians who are listed on its website to share patient reviews so that potential patients can consider this feedback in choosing a potential physician. You are being asked by the Medical Group to complete a Patient Feedback Form about your Physician and to let our Medical Group share that Patient Feedback Form with ZocDoc to market the services that your Physician provides. The Patient Feedback Form will contain information that could identify you (such as your name) and may reveal information about your health, for example, the type of doctor you are seeing. It will also include the feedback information that you choose to provide.
By signing this form, you allow the Medical Group to disclose the Patient Feedback Form to ZocDoc. The Medical Group will not disclose, pursuant to this authorization, any additional information besides what is on the Patient Feedback Form. Once ZocDoc receives your Patient Feedback Form, you understand that it will decide whether to post your feedback on its website. If it does post the feedback, your first name and last initial may also be disclosed along with any other information in the Patient Feedback Form. Your decision to sign this permission form allows ZocDoc to use and share your Patient Feedback Form in connection with marketing the Physician and Medical Group's services. You understand and agree that ZocDoc may process the Patient Feedback Form outside of the United States.
This permission form does not expire. If you decide you want to revoke this permission, you may do so anytime by contacting the person listed below, who will inform ZocDoc to remove the feedback from its website. Please note that your decision to cancel your permission for ZocDoc to use and share your Patient Feedback Form will only apply to future availability of your feedback on the ZocDoc website and will not affect the presence of your feedback on cached, archived, or similarly saved versions of the ZocDoc website. You should also understand that state or federal law may allow someone who gets your information from the ZocDoc website to use or release it in some way not discussed in this form. In addition, even if you revoke your permission and ZocDoc removes your feedback from its website, your information may already have been copied and shared elsewhere on the internet or in other ways. ZocDoc will not be able to withdraw that information or prevent it from being seen or shared.
It is important to remember that not signing this form or later canceling your permission will not affect your health care treatment from your Physician, payment for health care from a health plan, or your ability to get health plan benefits.
I have read this form. I understand it and agree to its terms.
8/22/18
Your Signature or Your Personal Representative's* Signature Date
Kemberly Palomegre
Print Your Name or the Name of Your Personal Representative*
My authority to sign as the Personal Representative of the Persons giving this permission is as:

Parent Legal Guardian Power of Attorney Other
Revocation Contact Person:



Provider Name (First a	and Last): Mohammad	Alam		
Patient First Name:	Ayera	400 100000 100000	Patient Last Initia	al: A
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By signing this form, you allow the Medical Group to disclose the Patient Feedback disclose, pursuant to this authorization, any additional information besides what receives your Patient Feedback Form, you understand that it will decide whether the feedback, your first name and last initial may also be disclosed along with an Your decision to sign this permission form allows ZocDoc to use and share your the Physician and Medical Group's services. You understand and agree that Zo outside of the United States.	at is on the Patient Feedback Form. Once ZocDoo er to post your feedback on its website. If it does any other information in the Patient Feedback Forn or Patient Feedback Form in connection with mark	c post m.			
This permission form does not expire. If you decide you want to revoke this permission, you may do so anytime by contacting the person listed below, who will inform ZocDoc to remove the feedback from its website. Please note that your decision to cancel your permission for ZocDoc to use and share your Patient Feedback Form will only apply to future availability of your feedback on the ZocDoc website and will not affect the presence of your feedback on cached, archived, or similarly saved versions of the ZocDoc website. You should also understand that state or federal law may allow someone who gets your information from the ZocDoc website to use or release it in some way not discussed in this form. In addition, even if you revoke your permission and ZocDoc removes your feedback from its website, your information may already have been copied and shared elsewhere on the internet or in other ways. ZocDoc will not be able to withdraw that information or prevent it from being seen or shared.					
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I have read this form. I understand it and a	agree to its terms.				
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Your Signature or Your Personal Representative's* Signature	Date	eran varribanan vuonne rar			
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* My authority to sign as the Personal Representative of the Persons giving	ng this permission is as:				
Parent Legal Guardían Power of Attorney Other					
Revocation Contact Person:					
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ZocDoc

Provider Na	me (First and Las	·+\-			
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How woul	d you rate th	is professional's	bedside manner?		
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By signing this used and proc	s form you acknow cessed (including	rledge that your provide outside of the United S	er gave you an authorization tates), and that you have sig	form explaining how this in ned and returned that autho	formation would be rization.

Signature: Feves 2

Date: 3/17/17

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ZocDoc

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Patient First Name: TECTED	A		Patient Last Initial:	4
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ZocDoc

Provider Name (First and Last): **Patient First Name:** NORMAN Patient Last Initial: Written reviews require your first name and last initial to appear next to this review on the ZocDoc website. What did you think about your visit? attestive to DEtail Would you recommend this professional? **大××××** →★★☆☆ Highly Recommended Probably Maybe Probably Not Never How would you rate this professional's bedside manner? ★☆☆☆☆ Excellent Satisfactory Unsatisfactory Awful How long was the wait time in the office before you were seen? * **** ★★★☆☆ ★☆☆☆☆ Right Away Less than Between Over 1 hour Over 2 hours 30 minutes 30 and 60 minutes

By signing this form you acknowledge that your provider gave you an authorization form explaining how this information would be used and processed (including outside of the United States), and that you have signed and returned that authorization.

Signature: Asmul

Date: 3/17/17

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