HEALTHIX, INC.
ONE-TO-ONE EXCHANGE AUTHORIZATION (THE "AUTHORIZATION")

A. _____ **("PPS Lead")** and _____ **("Downstream Provider")** (collectively "Parties") are participants in a Performing Provider System ("PPS") and of Healthix, Inc. ("Healthix"). The Parties wish to exchange patient data via the Healthix health information exchange for purposes of the New York State Department of Health's Delivery System Reform Incentive Payment program ("DSRIP"). In relation thereto, The Parties acknowledge and agree to the following:

1. They are permitted to exchange information pursuant to a reciprocal Business Associate Agreement (i.e., for certain purposes the PPS Lead is the business associate of the Downstream Provider and for other purposes the Downstream Provider is the business associate of the PPS Lead).

2. PPS Lead has obtained necessary authorization from New York State to provide New York State Medicaid information (e.g., the list of attributed patients) to Healthix.

3. The exchange of information is for purposes permitted under New York State regulations for the SHIN-NY and related guidance ("NY Statewide Guidance") and Healthix Policy.

4. The proposed exchange of patient data constitutes a One-to-One Exchange under NY Statewide Guidance and Healthix Policy, and therefore, a patient consent to the health information exchange is not required.

5. The Parties acknowledge and agree that information specially protected pursuant to the Federal Substance Abuse Treatment Confidentiality Laws (42 CFR Part 2) is not intended to be exchanged pursuant to this Authorization and Healthix will take steps to prevent information from substance abuse treatment programs from being transmitted as part of the One-to-One Exchange described in this Authorization.

B. The Parties direct and authorize Healthix to facilitate the One-to-One Exchange described above.

C. To initially facilitate the One-to-One Exchange described above:

1. PPS Lead will send to Healthix on a regular, ongoing basis, updated lists of patients and providers who are participating in the PPS.

2. As necessary, the Downstream Provider or PPS Lead, as applicable will provide the information needed for Healthix to route such data to the intended recipient.

3. The patient health information exchange via Healthix will be based on the following submission:
   - Unidirectional; From PPS Lead (1) to Downstream Provider (2) (1->2)
   - Unidirectional; From Downstream Provider (2) to PPS Lead (1) (2->1)
   - Bidirectional; From PPS Lead (1) to Downstream Provider (2) and From Downstream Provider (2) to PPS Lead (1<->2)

4.

D. The Parties acknowledge and agree that, in conjunction with Healthix and with the guidance of the New York State Department of Health, as applicable, the NY Statewide Guidance or Healthix Policy may be revised in the future in a way that would require this Authorization to be changed. Healthix agrees to notify the PPS Lead and the Downstream Provider of any changes to the NY Statewide Guidance, Healthix Policy, or other authority that would require revision of this Authorization.

E. This Authorization shall remain in effect until the PPS Lead or the Downstream Provider provides notice of termination at least ninety (90) days in advance to Healthix.

F. The terms of the Participation or Services Agreement, as applicable, between Healthix and the individual Parties, including any indemnification provisions, will apply to this Authorization.

G. This Authorization may be executed in any number of counterparts, each of which will be deemed an original as against the Party whose signature appears thereon, but all of which taken together will constitute but one and the same instrument.

H. **(PPS Lead Name and (Downstream Provider Name)** agree to be audited on a regular basis to assure that applicable requirements were met where Protected Health Information was accessed through one to one exchange.

[*PPS LEAD NAME*]

Signature _____
(Officer or Authorized Rep)

Print Name _____

Title _____

Date _____

[*DOWNSTREAM PROVIDER NAME*]

Signature _____
(Officer or Authorized Rep)

Print Name _____

Title _____

Date _____

Acknowledged and Agreed:

HEALTHIX, INC.

Signature: _____
Todd. M. Rogow
President & CEO

Date: _____

Last Updated: Sept. 4, 2020