AUTHORIZATION TO USE AND DISCLOSE MY HEALTH INFORMATION

By signing this Authorization, I am authorizing my pharmacies, physicians, other health care providers, health plan(s), health insurers, and the agents and contractors of any of these entities (collectively, “Health Care Entities”), to use and disclose to ScriptHero LLC (d/b/a the “ScriptHero Marketplace") and its affiliates and subcontractors (collectively “ScriptHero”) My Health Information (as described below) for ScriptHero to use and disclose such information for the following purposes:

- To facilitate my treatment and health care, including, but not limited to:
    - Providing information about my health or medical conditions (“Conditions”) or my current or future treatment, including any medical devices, biological therapies, or medications I may use or be prescribed (“Medications”);
    - Estimating the costs of health care services and prescription medications;
    - Verifying my insurance information and coverage;
    - Evaluating my eligibility for, and enrolling me in, manufacturer-sponsored patient-support programs (“Programs”);
    - Providing me with support services offered as part of Programs (for example: nursing assistance, patient education and adherence support);
    - Communicating with me, my healthcare providers, health plans, pharmaceutical manufacturers and other possible sources of financial or patient support, about my Conditions, Medications, medical care or treatment; and
    - Providing my information to researchers conducting studies or clinical trials to determine if I qualify to participate and to contact me if I do.
- To send me, or permit business affiliates to send me, information about products and services that may be of interest to me, including:
    - Offers, products, services or programs available from ScriptHero or third parties, such as discount card vendors or pharmaceutical manufacturers, including, but not limited to, affordability programs, clinical trial opportunities or prescription delivery;
    - Surveys from ScriptHero or third parties (e.g., pharmaceutical manufacturers) about products and services related to my Condition(s);
    - Programs to help me pay for or remain adherent to my medications or that provide support and information regarding my Medications and Conditions; and
    - Educational materials about my Conditions and Medications, including information and messages from pharmaceutical manufacturers and other third parties.
- To operate ScriptHero and provide its services, including, but not limited to:
    - Administering any programs or services it offers on its own behalf or on behalf of discount card vendors or pharmaceutical manufacturers, including using your Health Information to provide you with individualized health insights or lifestyle tracking;
    - Providing customer service;

    - Establishing, servicing and performing operations related to my online profile on ScriptHero's website(s), mobile application(s) or through third-party integrations(s); and
    - Performing other internal operations.
- To improve the ScriptHero website(s), mobile application(s), products or services;
- To develop and test new products and services, and to perform surveys (including surveys directed to my Health Care Entities), market research;
- To report raw data, perform data analytics and share such data and analytics with you, your Health Care Entities, and other third parties (e.g., pharmaceutical manufacturers).

My Health information that will be used and disclosed, as described in this Authorization, includes, but is not limited to, my name, demographic (e.g., gender and date of birth), contact information, device information, insurance information, and information about my Conditions, treatment, diagnoses, and medications ("My Health Information"). I understand that My Health Information may include my entire medical record and information about my mental health, alcohol and drug abuse, family planning and pregnancy, communicable diseases, HIV/AIDS, sexually transmitted diseases, genetic testing and information, and developmental disabilities, as applicable.

Remuneration and Redisclosure: I understand that my Health Care Entities may receive payment or other remuneration from third parties for disclosing My Health Information, as described in this Authorization. I understand that, once any of my Health Care Entities disclose My Health Information to ScriptHero based on this Authorization, My Health Information may no longer be protected by applicable federal and state privacy laws and may be re-disclosed by the person or entity who receives it.

My Rights with Respect to this Authorization: I understand:

- This Authorization is voluntary. My refusal to sign this Authorization will not affect my ability to obtain treatment services from my physician practice, pharmacy or other health care providers, receive payment, enroll in a health plan, or be eligible for benefits. However, I understand that I may not be able to obtain ScriptHero's full functionality and services if I do not sign the Authorization.
- I have the right to withdraw or revoke my Authorization at any time by contacting privacymatters@scripthero.com.
    - My revocation will not be effective for uses and disclosures of My Health Information that may have occurred prior to the processing of my revocation of this Authorization.
- This Authorization will expire five (5) years after the date I sign or otherwise execute it, unless I revoke this authorization prior to the expiration date stated above.
    - For residents of Maryland: This Authorization will expire one (1) year after the date I sign or otherwise execute it, unless I revoke this authorization prior to the expiration date stated above.

    - For residents of Maine and Montana: This Authorization will expire thirty (30) months after the date I sign or otherwise execute it, unless I revoke this authorization prior to the expiration date stated above.
- I have been given or provided the opportunity to save, print, copy or otherwise obtain a copy of this Authorization.

BY AGREEING TO THIS AUTHORIZATION, I UNDERSTAND THAT MY HEALTH INFORMATION MAY BE USED AND DISCLOSED AS DESCRIBED IN THIS AUTHORIZATION.

If signed by the Patient's Legal Representative: Please prescribe the authority to act on the patient’s behalf.

I certify I am the Legal Representative of the individual who is the subject of this Authorization and authorized to sign this consent on behalf of that individual.