**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, _____ (the "Patient"), hereby voluntarily authorize the disclosure of information from my health record as further described herein.

1. **This information is to be disclosed to:**

Face Reality, LLC
730 Camino Ramon, Suite 200
Danville, CA 94526

2. **Purpose of Disclosure:** The purpose of this disclosure is to permit Face Reality, LLC ("Face Reality") to utilize the Patient's medical records and treatment notes for internal studies, publicity, and advertisement purposes.

3. **Scope of Disclosure:** I understand that this form authorizes Face Reality to disclose any of my medical records and treatment notes for internal studies, publicity, and advertisement purposes. I understand that if and when Face Reality uses my treatment notes and medical records, some of my medical records will no longer be subject to HIPAA or other protections. I understand and agree to waive those protections.

4. **Right to Refuse to Sign Authorization:** I understand that I am under no obligation to sign this form and that Face Reality may not condition treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

5. **Right to Revoke Authorization:** I understand that I have the right to revoke this authorization at any time by providing a written statement of revocation to Face Reality's medical records or billing staff. I am aware that my revocation will not be effective until received by Face Reality and will not be effective regarding the uses and/or disclosures of my health information that Face Reality has made in reliance of this authorization prior to receipt of my revocation statement. I understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

6. **Right to Inspect or Copy My Health Information:** I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I understand that to inspect and copy medical information, I must submit my request in writing to Face Reality's medical records or billing staff. If I request a copy of the information, I understand that Face Reality may charge a reasonable cost-based fee in accordance with applicable law to fulfill my request.

7. **Right to Receive Copy of This Authorization:** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

8. **Notice of Re-disclosure.** I understand that if my medical information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by a person who receives my

medical information and may not be protected by applicable privacy law.

9. **Date of Expiration:** This authorization will expire at the end of ten (10) years from the date below unless validly revoked before that date.

Dated this ____ day of _____, 2023

_____
Patient Name