HIPAA AUTHORIZATION
FOR COMMUNICATIONS USING RHINOGRAM

PATIENTS NAME ____ DOB __________

1. I authorize the access, use, and/or disclosure of my information by
   ____
   (including its providers and clinical and administrative staff members) (the "Practice") in relation to our patient/provider relationship, as described below.

2. The type and amount of information to be accessed, used and/or disclosed is as follows: (1) communications between myself and the Practice for treatment, payment and/or health care operations via Rhinogram's communications platform across digital, social media, texting, and/or other communication channels (the "Platform"); and (2) transmissions of m y patient information for treatment purposes only sent and/or received between the Practice and my other treatment providers (or other providers to whom the Practice refers me) via the Platform.

3. I understand that I have the right to revoke this Authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

4. Unless revoked earlier, this Authorization will expire on the following specified date, even or condition: expiration or termination of my patient/provider relationship with the Practice.

5. I understand that once information is disclosed pursuant to this Authorization, it may be re-disclosed by the recipient and may not be protected by federal privacy regulations.

6. I understand that the Practice may not condition, prohibit, or prevent my treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.

7. I understand that I will be given a copy of, or access to, this Authorization form after it is signed.

Signature of Patient or Personal Representative ____