AUTHORIZATION TO USE AND DISCLOSE
MY HEALTH INFORMATION

Completion of this document ("Authorization") authorizes my Health Care Provider (as defined below) to disclose and use my health information for the purpose(s) described below. Please carefully read and provide the information requested.

I, _____(*full name*), authorize the use and disclosure of my health information as described below:

I. Description of Health Information.

This Authorization applies to all my medical records, including my entire health record, which are in the custody of _____ ("Health Care Provider").

II. Authorized Person(s).

I authorize my health care providers and professionals to disclose my health information to Novellia, Inc. ("Novellia").

III. Purpose of Use or Disclosure.

The purposes of this disclosure are to allow: (1) me to use Novellia's platform to manage and aggregate my health information in one location that is accessible to me and (2) Novellia to use my health information for research, evaluation, and analysis activities.

This Authorization does <u>not</u> permit the disclosure of my: (i) psychotherapy notes, (ii) HIV or AIDS test results, (iii) information concerning my participation in a substance use disorder treatment program, or (iv) information obtained in the course of providing mental health services.

IV. Expiration of Authorization.

This Authorization expires twenty-four (24) months from the date of my signature below.

REFUSAL TO SIGN:

I understand that:

(1) I may refuse to sign this Authorization and that my health care providers and professionals may not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this Authorization.

(2) Under no circumstances am I required to authorize the disclosure of psychotherapy notes.

REDISCLOSURE:

I understand that if I authorize the disclosure of health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. However, if the disclosure of my health information is subject to California law, I understand the person receiving my health information is prohibited from making further disclosure unless another authorization is obtained or unless such disclosure is permitted or required by law.

REVOCATION:

I understand that: (1) I may revoke this Authorization at any time; (2) my revocation must be in writing, signed by me or on my behalf, and delivered to my Health Care Provider at the address below; (3) I may review the notices of privacy practices of my Health Care Provider for further information. My Health Care Provider's contact information is stated below.

I understand that: (1) I may deliver my revocation by any means I choose (*e.g.,* personally, electronic mail or by mail), but it will be effective only when my Health Care Provider actually receives it; (2) my revocation will not be effective to the extent that my Health Care Provider or others have already acted in reliance upon this Authorization.

Health Care Provider's Address: _____

Health Care Provider's Electronic Mail Address: _____

COPY:

I have a right to receive a copy of this Authorization. My Health Care Provider will provide me with a signed copy of this Authorization and instructions on how to access additional copies or a digital version of the signed copy of this Authorization.

Remainder of Page Left Intentionally Blank; Signature Page Follows

SIGNATURE.

I understand and agree to the foregoing:

Date: _____ Signature:_____

Print name of person signing:_____

Print name of individual whose health information is sought to be released:_____

If you are signing as the individual's representative:

Print your name:_____

Describe your authority:_____.