AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Authorization to Disclose Information. I authorize my healthcare providers and their vendors (collectively, "Providers") to disclose my health data and protected health information (collectively "PHI") to Vim, Inc. ("Vim") and telehealth partners ("Care Partners") and their respective vendors for purposes of evaluating my eligibility for and, if I choose to participate, facilitating my access to chronic disease management and education programs ("Programs"). This includes sending me marketing communications about the Programs.

Information Disclosed: Providers may disclose the following PHI: treatment and diagnostic information relevant to the Programs, demographic information (e.g., age, gender), and contact information (e.g., name, address, phone, email).

Term and Revocation: This authorization shall remain in effect for five (5) years from the date of execution or the duration permitted under applicable state law, whichever occurs first. I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification of the revocation to [HCP email/physical address], except to the extent that my Providers have already acted in reliance upon this authorization.

Redisclosure and Rights: I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of such information and may no longer be protected by federal or state law. Providers may not condition my treatment, payment, enrollment, or eligibility for benefits on whether I provide this authorization except as otherwise permitted by law. I do not need to provide this authorization, but if I do not provide this authorization, I may not be able to participate in the Programs. I may request a copy of this authorization.

By checking and signing my name below, I acknowledge that I have read and agree to the terms of this authorization and authorize each Provider to disclose my information to Vim, Care Partners, and their vendors as described herein.

□ I agree to the terms of this authorization.

_____ _____

Patient Name Date