AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NOTE: This authorization is separate from, and in addition to, the uses and disclosures of my information detailed in the https://apollo.ahnphealth.com/privacy.

Use and Disclosure by Apollo

I hereby voluntarily authorize the use and/or disclosure of all or any part of my health information as described in this authorization by AHNP, LLC d/b/a AHNP Precision Health ("Apollo") and its employees, agents, and third parties acting on its behalf for the following purposes:

- To enable Apollo to provide me with its integrated system of genetic, blood/biomarker, and behavioral testing that prepares patients for prevention and treatment protocols for Alzheimer's Disease and Type 2 Diabetes (the "Apollo Program"); and
- To enable Apollo to analyze and improve the Apollo Program.

Apollo may disclose my health information for the above-stated purposes to the Provider identified below and Apollo's agents, third parties acting on its behalf, and other third parties participating in one of the above-stated activities.

Use and Disclosure by Provider

Additionally, I hereby voluntarily authorize the use and/or disclosure of all or any part of my health information as described in this authorization by my provider and his or her employees, agents, and third parties acting on his or her behalf to enable Provider to provide me with health care services provided in connection with my participation in the Apollo Program. Provider may disclose my health information for this purpose to Apollo, and Apollo may further use and disclose my health information for this purpose and any other purpose permitted in this authorization. Provider may also disclose my health information to Provider's agents, third parties acting on its behalf, and other third parties participating in the provision of health care services to me.

Health Information

My health information used and/or disclosed by Apollo and Provider may include, but is not limited to, the following: name, address, phone number, email address, date of birth, insurance status and numbers, diagnosis information, laboratory results, and treatment information.

General Terms

My acceptance of this authorization means that I understand and agree to the following:

- My health information may be protected by law. I understand that the health information that is disclosed under this authorization may be re-disclosed by the recipient and no longer protected by federal privacy laws. However, California law, which will apply in the event that Provider practices in the State of California, prohibits the recipient from making further disclosure of my health information, unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I understand that I do not need to agree to this authorization in order to receive treatment from Provider. However, I do need to agree to this authorization in order to participate in the Apollo Program.
- I understand that I have the right to revoke this authorization at any time by notifying Apollo in writing at Apollo Health, Attention: Privacy Administrator, P.O. Box 117040, Burlingame, CA 94011. Revoking this authorization will not have any effect on actions that Apollo or Provider took in reliance on this authorization before they received notice of my revocation.
- If I do not revoke this authorization, this authorization will expire one (1) year from the date on which I accept its terms.
- I understand that I may receive a copy of this authorization if I ask for it in writing addressed to Apollo at the address above.