HIPAA Marketing Authorization

Blackstone Medical Services, LLC ("Blackstone") may wish to communicate with you about additional products and services through Sleep Health (the "App"). Blackstone respects your privacy and strives to comply with applicable privacy laws, like the Health Insurance Portability and Accountability Act ("HIPAA"). Before Blackstone can make certain communications to you, your written consent and authorization is required. Such communications may include, but are not limited to, communications about products or services that encourage you to purchase or use the products or services, and/or communications that are sponsored or reimbursed by a third-party whose products or services are promoted in the communication.

By signing this Authorization, you understand that you are giving Blackstone permission to use or disclose your protected health information, including your name, mailing address, email address, and medical conditions to send you marketing communications, as defined under HIPAA. You understand Blackstone may receive direct or indirect payment or remuneration from a third-party for making these communications.

You understand you have the right to revoke this authorization at any time by providing written notice of your revocation to: 550 N Reo St, Ste 250 Tampa, FL 33609 | privacy@blackstonemedicalservices.com. You understand that this authorization is valid until it is revoked in writing.

You understand that revocation of this Authorization will not affect any action Blackstone and/or the App took in reliance on this Authorization before receiving your revocation.

You agree to hold harmless and release Blackstone and the App from all claims, demands and causes of action which you, your heirs, representatives, executors, administrators or any other persons acting on your behalf or on behalf of your estate have or may have by reason of this Authorization.

If neither federal nor state privacy laws apply to the recipient of the information, you understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state privacy law.

You may inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization form.

This Authorization is voluntary and you understand that you may refuse to sign. You understand that your refusal to sign this Authorization will have no effect on the medical treatment you receive.

_____

Patient/Caregiver/POA Printed Name

_____ _____

Patient/Caregiver/POA Electronic Signature Electronic Signature Date