NightWare, Inc and the NightWare Digital Therapeutic Device

HIPAA AUTHORIZATION

This document provides NightWare, Inc ("NightWare") and/or its employees, and its agents, including its distributors, product development partners, and trainers Authorization to use your Personal Information ("Information") and/or Protected Health Information ("PHI") in ways that go beyond those already authorized under the Health Insurance Portability and Accountability Act ("HIPAA"). NightWare requests this Authorization to support its business process and its provision of services to you. For more information, please see NightWare's **Privacy Policy** and **Notice of Privacy Practices**, available at www.nightware.com/privacy-and-compliance/

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1. **Authorization of Uses and Disclosures**. I hereby authorize and direct NightWare to use and disclose my Information and/ or PHI, as described below. I also authorize NightWare to contact me via telephone, mail, e-mail (including unencrypted e-mail), or by other means of communications.

2. **Description of PHI / Information**. I understand that my PHI and Information includes, but is not limited to, my name and other personal information (including my address), information from a NIghtWare Digital Therapeutic prescription form, medical information about me including information about related medical conditions, medical records, or reports, and financial information (including information about my insurance) as well as other personal information about me collected by NightWare.

3. **Purposes.** I authorize and direct NightWare to use and disclose my Information and/or PHI for the following purposes: (a) reviewing PHI / Information about me, and using and disclosing that information to coordinate or arrange delivery of supplies related to NightWare products, services, or training, including those products or services not yet furnished to me by NightWare and/or it's agents; (b) providing product updates, including regulatory notices relating to existing or future products; and (c) providing information that may inform me, or promotes medical products and/or services that may be of interest to me.

4. **Coverage**. I understand that a quote of benefits and/or coverage authorization does not constitute payment or eligibility for a NightWare product or service. Payment of benefits are subject to the terms, conditions, limitations and exclusions of the member coverage contract at the time of service.

5. **Expiration**. This Authorization expires the later of when I no longer am a customer of NightWare, or ten (10) years after the date of this Authorization.

6. **Revocation**. I understand that I have the right to revoke this Authorization at any time by sending a written request to NightWare here: Attention Privacy Officer, 8900 Excelsior Boulevard, Hopkins, MN 55343. However, I understand that such revocation will not be effective with respect to Information and/or PHI that has already been used and/or disclosed by NightWare in reliance on this Authorization.

7. **Treatment Not Conditioned**. I understand that NightWare will not deny me treatment, products, or services I am entitled to based on whether or not I sign this Authorization, or if I decide to revoke this Authorization at some point in the future.

8. **Potential for Redisclosure**. I understand that Information disclosed pursuant to this Authorization may be redisclosed by recipients (including me) and may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA"), a federal privacy law.

9. **Copy**. I understand that I will be provided with a copy of this signed Authorization by NightWare.

Patient Name: _____

I have read, understand, and agree to the above Terms and Conditions of this HIPAA Authorization

Date: _____

Patient Signature (or Representative Authorized by Patient and Relationship to Patient):

X _____