Patient Authorization for Use & Disclosure of Protected Health Information & Patient Appointment of Representation

HIPAA Privacy Rule, 45 C.F.R. §164.508(c)(1)

Authorization for Use and Disclosure of my personal information

I, _____ **(Name, First and Last),**

_____ **(DOB)** hereby authorize

_____ **(Doctor and/or Practice Name)**, as well as any health plan, physician, or other health care professional that has provided treatment or services to me to disclose my personal information ("Personal Information") to SPR® Therapeutics, Inc. and any of its affiliates or service providers engaged on its behalf (collectively "SPR") for the purpose of providing patient access support through its SPRcare® Patient Access Program ("SPRcare") in connection with securing insurance coverage for my therapy with the SPR SPRINT® PNS System. My Personal Information includes, but may not be limited to, my name; my health information, demographic, contact and insurance information; date of birth and the following information: (i) MEDICAL RECORDS: Hospital and Clinic medical records and notes, including but not limited to, information regarding my treatment, medical history, diagnoses; tests and test results; all correspondence regarding my medical care, treatment history and prognosis; and (ii) INSURANCE/BILLING RECORDS: appeals/grievances information; enrollment and benefit information; all communications, notes, claim forms, or other documents regarding payment for my medical care related to my therapy with the SPR SPRINT PNS System including evaluating, adjusting, processing or paying my claim(s) for insurance benefits, whether pre-service or post-service in nature.

I further AUTHORIZE SPR to use and disclose my Personal Information for the SPRcare Patient Access Program, including to seek, obtain and appeal decisions related to my insurance coverage for my therapy with the SPR SPRINT PNS System, and as described in SPR's

SPR Consumer Health Data and Information Privacy Policy at SPRPainRelief.com/consumer-health-data-and-information-privacy-policy and for related business purposes.

I understand that this authorization is voluntary and that my treatment, payment for my treatment, enrollment or eligibility for benefits is not conditioned upon whether I sign this form. I understand that once my Personal Information is disclosed it may be subject to redisclosure and no longer protected by federal privacy law. I understand that my Personal Information may contain **SENSITIVE INFORMATION**, such as information regarding my past, present and future medical conditions and diagnoses, mental health, substance use or dependency, sexually transmitted diseases, and confidential HIV/AIDS related information.

I understand that SPR will use my Personal Information only for the purposes described herein, to administer SPRcare or as otherwise required or permitted under applicable laws.

This Authorization will expire on the later of one year from the date entered below OR upon conclusion of any appeal efforts being undertaken by SPR, unless a shorter time is required under applicable state law. I understand that I may revoke this Authorization at any time by notifying SPRcare in writing at 7225 Northland Drive N Suite 320, Brooklyn Park, MN 55428, and if I do, my revocation will not affect any actions taken before my revocation or in reliance on my Authorization.

Patient Signature: _____

Printed Name: _____ **Date:** _____

Appointment of SPR as Authorized Representative: I hereby designate and appoint SPR to act as my Authorized Representative(s) to assist me with seeking coverage for my therapy with the SPRINT PNS System, and, if applicable, the appeal of my insurance denial, and, as such, to sign any appeal forms on my behalf that are required by my insurance plan. I understand that I am not establishing an attorney-client relationship with SPR or its representatives, and that I may revoke this Appointment at any time by notifying SPRcare in writing; and if I do, it will not affect any actions taken before my revocation.

I understand that SPR (i) has not provided me with any guarantee or assurance that I am eligible for the SPRcare program; (ii) has not promised me that I will obtain insurance coverage for my therapy; (iii) may decline, in its sole discretion, at any time, to pursue coverage for me; and (iv) will not subsidize my care. Entering into this arrangement will not alter any financial responsibilities I have to my health care provider or any other third-party. I understand that I may be asked to cooperate with SPRcare as it provides assistance with my efforts to secure coverage, and that my failure to do so may negatively affect the outcome. While I understand there are no costs for me to participate in SPRcare, some third parties may require payment for copying records. Accordingly, I understand if I want those records to be a part of my appeal, I will be responsible for paying those costs.

Patient Signature: _____ **Printed Name:** _____

Date: _____ **Phone Number:** _____

This authorization form must be completed in its entirety – incomplete forms cannot be processed.

For additional information regarding how your personal information is used or collected (including your rights and additional State specific notices), please see the SPR's Consumer Health Data and Information Privacy Policy at SPRPainRelief.com/consumer-health-data-and-information-privacy-policy