West Dermatology and its Affiliates understand that information about you and your health is personal and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special Authorization before we may use or disclose your protected health information for communications about products or services.

This form provides that Authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before providing your electronic Authorization of this form. A representative of West Dermatology is available to answer any questions regarding this Authorization.

AUTHORIZATION FOR MARKETING COMMUNICATIONS

I hereby authorize and consent to West Dermatology and its Affiliates[1] to disclose my protected health information and send me information that may be of interest to me, including but not limited to marketing information on new products and services provided by West Dermatology and/or its partners.

I understand that my information will be disclosed for marketing purposes through email and SMS (short message service or text) methods. I understand this Authorization is voluntary and I may refuse to sign. West Dermatology and its Affiliates may not condition my health care services or payment, or enrollment or eligibility for benefits on the completion of this Authorization form.

Unless otherwise revoked, I understand this Authorization will expire 50 year(s) from the date of signature. I understand I may revoke this Authorization at any time, except to the extent West Dermatology and its Affiliates have relied on this Authorization. I agree that I may revoke this Authorization electronically and that my electronic revocation is the legal equivalent of my writen revocation.

I understand that if my information would be disclosed for a marketing purpose as defined by the Health Insurance Portability and Accountability Act (HIPAA), then West Dermatology and its Affiliates could receive direct or indirect remuneration from a third party in connection with the use or disclosure of my information.

I understand that the records used and disclosed pursuant to this Authorization may include information relating to: patient ID, name, address, telephone number, email address, dates of

[1] "West Dermatology and its Affiliates" includes West Dermatology affiliated business units, entities and subsidiaries including, but not limited to, include West Dermatology/J. Robert West, M.D., Inc., English Dermatology, P.C., Las Vegas Skin and Cancer Clinics, Cosmetic Laser Medical Associates of La Jolla, Inc., Glenn I. Goldberg, D.O., Coast Dermatology, Newport Dermatology and Laser Associates, Beverly Dermatology and Laser Center, Santa Barbara Skin Care, Silverberg Surgical and Medical Group, Yuma Dermatology and Hodge Dermatology, and any company that is or has been acquired by the above organizations.

service, age and gender, and medical condition to communicate with you about products or services.

I understand that to the extent any recipient of this information, as identified above, is not a "covered entity" under the Federal or state privacy laws, the information may no longer be protected by Federal and state privacy law once it is disclosed to the recipient, and, therefore, may be subject to re-disclosure by the recipient.

I hereby release West Dermatology and its Affiliates, and their directors, officers, agents and employees from any and all liability, claims, suits, demands, or causes of action whatsoever which I, my heirs, representatives, executors, administrators, or any other person acting on my behalf or on behalf of my estate may have by reason of this Authorization or the capture, use, or release of the reproductions.

I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific Authorization or permission, including disclosures to covered entities as provided by 45 C.F.R. § 164.502(a)(1).

By signing this Authorization, I represent to West Dermatology and its Affiliates, its agents and employees that I am of sound mind, and that I have read the Authorization and fully understand the terms contained herein. I understand that West Dermatology and its Affiliates will provide me with a copy of this signed Authorization form.

I hereby agree that I am signing this Authorization electronically, and that my electronic signature is the legal equivalent of my manual signature on this Authorization.

"