AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES

1. Authorization

I authorize **CCRM Newport Beach, Inc.** ("Covered Entity") to use and/or disclose my Protected Health Information ("PHI"), as defined in HIPAA, for marketing purposes as described in this Authorization.

2. Information to Be Used or Disclosed

This Authorization applies to all PHI maintained by the Covered Entity:

This PHI may include demographic information, contact information, health condition information, treatment information, provider information, insurance information, and other PHI maintained by Covered Entity, except as otherwise prohibited by law.

3. Persons Authorized to Use or Receive the PHI

Covered Entity may use and/or disclose my PHI to:

Marketing Partners, Vendors, Affiliates, Business Associates, Agencies, or Other Recipients, including CCRM Management Company, LP and Unified Women's Healthcare, LP.

4. Purpose of Authorization

My PHI may be used and/or disclosed for marketing purposes, including but not limited to:

- Communications regarding products, services, programs, events, promotions, educational opportunities, wellness initiatives, clinical offerings, provider offerings, healthcare-related products or services, and other marketing activities;
- Communications delivered by mail, email, telephone, text message, social media, digital advertising platforms, online platforms, mobile applications, or other communication methods;
- Audience development, outreach, campaign administration, and related marketing analytics.

5. Financial Remuneration Disclosure

- Covered Entity **does not** receive financial remuneration from a third party in exchange for making these marketing communications.

6. Expiration

This Authorization shall remain in effect until the earliest of:

- A new Marketing authorization is completed by me, or

- Revocation by me.

7. Right to Revoke

I understand that I may revoke this Authorization at any time by submitting a written revocation to:

contentmarketing@ccrmivf.com

I understand that revocation will not affect any use or disclosure that occurred before Covered Entity received and processed my revocation.

8. No Conditions on Treatment or Benefits

I understand that Covered Entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization, except as otherwise permitted by applicable law.

9. Potential Redisclosure

I understand that information disclosed pursuant to this Authorization may be redisclosed by the recipient and may no longer be protected by HIPAA or other federal privacy laws, depending on the recipient and applicable law.

10. Electronic Communications

I authorize Covered Entity and its authorized recipients to contact me through the following methods for marketing purposes:

- Mail
- Email
- Telephone
- Text/SMS
- Mobile Application Notifications
- Online/Digital Advertising
- Interactive Website or Platform

I understand that electronic communications may involve certain privacy and security risks.

11. Acknowledgments

By signing below:

1. I confirm that I have read and understand this Authorization.
2. I understand the nature and purpose of the uses and disclosures authorized herein.
3. I understand that signing this Authorization is voluntary.

4. I understand my right to receive a copy of this signed Authorization.
5. I authorize the use and disclosure of my PHI as described above.
6. I have the legal authority to sign this form (e.g., I am 18 or older).