TRUE USA SENIOR CONCIERGE, L.L.C.

HIPAA Authorization for Benefit Investigation — 45 CFR §164.508

I, the undersigned patient or Legally Authorized Representative (LAR), hereby authorize True USA Senior Concierge LLC to use and disclose my protected health information (PHI) solely for the purpose of conducting a benefit investigation on my behalf.

1. INFORMATION TO BE USED OR DISCLOSED

Name, date of birth, address, insurance information, medication information, and any other information necessary to conduct a benefit investigation.

2. WHO MAY RECEIVE THIS INFORMATION

Healthcare providers, insurance carriers, pharmacy benefit managers, specialty pharmacies, and senior service agencies — solely as needed to investigate, evaluate, and verify benefit coverage.

3. PURPOSE OF DISCLOSURE

To determine insurance coverage, prior authorization requirements, preferred specialty pharmacies, and available patient assistance programs.

4. TERMS & CONDITIONS

- **Expiration:** This authorization expires one (1) year from the date of signature, or upon written revocation sent to info@trueusasenior.com.
- **Right to Revoke:** You have the right to revoke this authorization at any time by submitting a written request to info@trueusasenior.com. Revocation does not apply to actions already taken in reliance on this authorization.
- **Voluntary Participation:** Signing this authorization is voluntary. You will not be denied treatment for refusing to sign. However, True USA Senior Concierge LLC cannot conduct a benefit investigation without this authorization.
- **Re-disclosure:** Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

ATTESTATION & ACKNOWLEDGMENTS

Identity & Legal Authority Attestation: I am the patient named above OR the legally authorized representative (LAR) with documented legal authority to execute this HIPAA authorization on behalf of the patient named above. All information I have provided is accurate and complete.

Right to Revoke Acknowledgment: I understand that I have the right to revoke this authorization at any time by submitting a written request to info@trueusasenior.com, and that revocation will not affect actions already taken in reliance on this authorization.

_____

Patient / Legal Representative Name (Printed)

_____

Signature (Patient or Legal Representative)

_____

Date