10. **HIPAA AUTHORIZATION.** I give permission to Guardian Pharmacy of [illegible] to use or disclose certain aspects of my health information to: the individual listed as my personal representative, my long-term care facility, federal and state health agencies, insurance companies, third-party data aggregators, pharmacy benefit managers, and other health-related agencies.

I have read and understand the above terms and conditions and agree to be bound by each of them:

Signature [Resident or Responsible Party]**: ____ Date: ___________________**

NOTICE OF PRIVACY PRACTICES [http://guardianpharmacy.net/hipaa-privacy-policy/]

I certify that I have received a copy of Guardian Pharmacy of [illegible] [illegible] opportunity to review the document and ask questions to assist my understanding [illegible] rights relative to the protection of [illegible] health information. I know that I can access the Notice of Privacy Practices on the Guardian Pharmacy website at [http://guardianpharmacy.net/hipaa-privacy-policy/]. I further acknowledge that I am satisfied with the explanations provided to me and am confident that Guardian Pharmacy of [illegible] is committed to protecting my health information. I certify that I have read and understand this agreement:

________**Resident or responsible Party Initial**

PAYMENT INFORMATION

I certify that I have received a copy of Guardian Pharmacy of [illegible] [illegible] and have been given an opportunity to and did review the document and was given an opportunity to ask questions to assist my understanding of it.

________**Resident or responsible Party Initial**

I understand and have reviewed all of the above documents and agree to be bound as applicable.

Signature [Resident or Responsible Party]**: ____ Date: ___________________**