General Consent and Release
Permission to Use Statements, Photographs, and Correspondence

We appreciate your agreement to tell your well story. Your thoughts, opinions and input are very valuable and will be considered as we evaluate ways to further improve and promote our products and programs. We would like to use your interview, testimonials, name, and opinions in our promotional media, case studies, and to help others better understand the benefits of our products and programs, consistent with the terms of the HIPAA Authorization to Use and Disclose Information you have signed ("HIPAA Authorization"); however, we need your permission to do so. We would greatly appreciate it if you would complete and sign this consent form. Once again, we thank you for your help and participation in this project.

The undersigned agrees and consents as follows:

I hereby give Sharecare, Inc., its subsidiaries, assignees, licensees, and legal representatives and their respective successors and assigns (collectively, "Sharecare") and _____ and its subsidiaries ("Customer"), the irrevocable and perpetual right and permission (unlimited as to the number of uses, times, and territory) to use, publish, and/or display my first and/or last name, my location (City and State where I live), my testimonial, interview, and opinions, my biographical information, my written, spoken, and recorded statements, my written correspondence, my voice, photographs, likenesses, or video recordings of me, and/or other information about me described in the HIPAA Authorization, in whole, in part, or in derivative works, as edited or unedited in Sharecare' and/or Customer's sole discretion, in all forms of media and in all manners, including advertising, trade, or any other lawful purposes, without compensation to me.

I understand and agree that such photographs, likenesses, and/or video recordings of me may be placed on the Internet. I also understand and agree that I may be identified by name and/or title in printed, Internet or broadcast information that might accompany the photographs and/or video recordings of me. I waive any right to inspect or approve the finished product, including written copy, that may be created in connection therewith. I agree that all such portraits, pictures, photographs, video and audio recordings, any reproductions thereof, all plates, negatives, recording tape, digital files, and all rights thereto, including copyrights, are and shall remain the property of Sharecare.

I hereby release, acquit and forever discharge Sharecare and Customer, and current and former agents, officers, and employees of the above-identified entities, from any and all claims, demands, rights, promises, damages and liabilities arising out of or in connection with the use, non-use, or distribution of said statements, correspondence, photographs and/or video recordings, including but not limited to any claims for invasion of privacy, appropriation of likeness or defamation.

I have read this release and am fully familiar with its contents. I hereby warrant that I am at least eighteen (18) years old and competent to contract in my own name or, if I am less than eighteen years old, that my parent or guardian has signed this release form below. This release is binding on me and my heirs, assigns, and personal representatives.

Participant's Full Name: _____

Participant's Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ E-mail address: _____

Participant's Signature: _____ Date: _____

–Continued on the next page if Participant is under eighteen (18) years old.–

If the Participant interviewed/photographed/recorded is under eighteen (18) years old, the following section must be completed by the Participant's Parent/Guardian:

I have read and I understand this document. I understand and agree that it is binding on me, my child (named above), our heirs, assigns and personal representatives. I acknowledge that I am eighteen (18) years old or more and that I am the parent or guardian of the child named above.

Parent/Guardian Signature: _____ Date: _____

Printed Name of Parent/Guardian: _____

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HIPAA Authorization to Use and Disclose Information

Participant's Full Name: _____

Participant's Address: _____

City: _____ State: _____ Zip: _____

I authorize Sharecare, Inc., its subsidiaries, assignees, licensees, and legal representatives ("Sharecare") and _____ and its subsidiaries ("CUSTOMER") to use and disclose my health information as described in this form.

1. Information to be Used and Disclosed. The information to be used and disclosed is limited to all of the following:

- My full name (First, Last, etc.)
- My title (Mr., Mrs., Dr.)
- My location (City and State where I live)
- My interview, testimonial, and opinions, including photographs and video recordings of me, and my written, spoken, and recorded statements, made and submitted to Sharecare and/or CUSTOMER.

2. Who May Use or Receive My Information. I understand that Sharecare and CUSTOMER may use and disclose my information for the purposes described in this form. Any person or entity learning about the programs and services of Sharecare or CUSTOMER or receiving marketing materials from Sharecare or CUSTOMER, including those visiting Sharecare or CUSTOMER's website, the media, and other third parties, may review my information referenced above. Also, Sharecare may disclose my information to CUSTOMER acting as my employer or as the sponsor of my group health plan. CUSTOMER, when acting as the sponsor of my group health plan, may disclose information it receives as a result of this authorization to individuals at CUSTOMER acting as an employer or service company (not as a benefits or plan administrator).

3. Purpose. My information may be used and disclosed for Sharecare and CUSTOMER's marketing communications and other efforts to inform the public and third parties about wellness programs and their benefits.

4. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to: **Sharecare**, **Attn: Privacy Officer; 701 Cool Springs Boulevard, Franklin, TN 37067**. However, my revocation shall not affect any uses or disclosures Sharecare and/or CUSTOMER may have made before my revocation was received.

5. Expiration. I understand that this authorization will expire one (1) year from the date that I sign it, except that Sharecare and CUSTOMER may continue to use and disclose any of my information that is contained in materials created by Sharecare or CUSTOMER as a result of this authorization for the purposes described above for as long as these items exist or until I have revoked this authorization.

6. Other. I understand that I have no obligation to sign this authorization. CUSTOMER will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this form. Any of my information that is released pursuant to this authorization may no longer be protected by federal privacy regulations (HIPAA), if the recipient(s) is not required to comply with federal privacy regulations. I understand that if CUSTOMER is acting as an employer, CUSTOMER is not subject to federal privacy regulations contained in HIPAA. Neither Sharecare nor CUSTOMER will receive payment from a third party for obtaining this authorization or engaging in the communications described above.

Signature: _____ Date: _____

If a Representative signs on behalf of the Participant, the following section must be completed by the Representative:

Printed Name of Participant's Representative: _____

Basis of Representative's authority to act for Participant: _____

Note: References to "me" or "my" (such as "my information") refer to the program Participant and not to the program Participant's Representative.

THE INDIVIDUAL WHO SIGNS THIS AUTHORIZATION SHALL BE PROVIDED WITH A COPY OF THE SIGNED FORM.