# Authorization for Zachriel Neurosciences to Use and Disclose My Protected Health Information (PHI)

I hereby authorize the use and disclosure of my health information as described below for the Zachriel Neurosciences (ZN) Pilot Treatment Program for Mild Cognitive Impairment and early-stage Alzheimer's.

**1. Description of PHI to be Used or Disclosed:**
This includes all medical records related to my diagnosis, treatment, and progression of Mild Cognitive Impairment (MCI) and early-stage Alzheimer's Disease (AD), including but not limited to clinical notes, imaging studies, laboratory test results, and medication records that will assist in the analysis and potential treatment of my MCI and early-stage AD by Zachriel Neurosciences.

**2. Persons Authorized to Use or Disclose Information:**
I authorize the research team at Zachriel Neurosciences to obtain and or disclose my information as it relates to my cognitive condition for the ZN MCI and AD Treatment Program.

**3. Persons Who May Use the PHI or to Whom the Disclosure Will Be Made:**
The disclosed information will be used by the research team at Zachriel Neurosciences, and may be shared with other regulatory bodies and other government agencies, including the FDA.

**4. Purpose of the Disclosure:**
The purpose of this disclosure is to analyze the process of MCI and early-stage AD and to improve the diagnosis and treatment strategies for them.

**5. Expiration:**
This authorization will expire upon the conclusion of the ZN Treatment Program or upon the date I submit a written request advising ZN to end this Disclosure Authorization.

**Required Statements:**

- **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by sending a written request to the ZN's Privacy Officer Robin Heinzer at privacyofficer@zachrielneurosciences.org My revocation will not affect any use or disclosures permitted by my authorization while it was in effect.
- **Conditions of Authorization:** My participation in this study is voluntary.
- **Potential for Re-disclosure:** I understand that information disclosed from my data as it relates to the ZN MCI and early-stage Alzheimer's pilot program may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

My signature below confirms my understanding of this Disclosure Authorization and my agreement to its terms and conditions as of the date signed below.

Print Name: ________________________________________

Signature of Participant: ______________________________ Date: ___________