jscreen Authorization to Use and Disclose Health Information

Dated: November 9, 2026

By registering for the jscreen program (the "Program") and signing the Program Participation and Informed Consent for Genetic Testing (my "Program Consent"), I have already authorized jscreen to collect certain identifiable health information and to provide it to my Ordering Clinician and to the laboratory or laboratories that perform my testing in order for me to receive certain genetic tests. This HIPAA authorization is made and agreed to in connection with my participation in the Program and will permit jscreen to use this information, as well as the information set forth below, in accordance with this authorization.

By signing this form, I authorize jscreen to associate and populate the form as necessary with the personal identifiable information that I enter in the jscreen Program registration process and to use the date of my electronic signature as the date of this authorization.

1. My Information

I am completing and signing this authorization electronically as part of the online clinical intake. I understand that it is a separate document from my Program Consent. I agree that jscreen can associate and populate the form as necessary with the personal identifiable information that I enter in the jscreen Program registration process and can use the date of my electronic signature as the date of this authorization. Capitalized terms not defined here have the meanings given in my Program Consent.

2. Who May Disclose My Information

The Clinical Providers who provide genetic counseling or testing to me through the jscreen Program, including Eye On Genetics, LLC ("**EOG**"), my Ordering Clinician, other Clinicians involved in my care, and each Testing Laboratory (which may"" be EOG's wholly owned clinical laboratory ("**EOG**" **Laboratory**") or another laboratory selected by EOG or my Ordering Clinician to perform all or part of my testing), and jscreen, LLC, acting on their behalf.

3. Information That May Be Disclosed

The following information about me may be disclosed:

- my name, contact information, date of birth, and demographic information, including ancestry;
- my personal and family health history, including information I provided in the online intake and any family pedigree;
- genetic test orders, genetic test results and reports, any genome sequence data or other genetic data generated from my sample, and other genetic information, including results that show carrier status or inherited disease or cancer risk;
- genetic counseling records and Clinician notes related to my genetic testing; and
- for the uses set forth in Section 4, any remaining sample of mine and the data derived from it, including any genome sequence data.

This authorization does **not** cover psychotherapy notes, substance use disorder treatment records protected by 42 C.F.R. Part 2, HIV/AIDS-related information, or mental health records, and it does not cover insurance or payment information except as stated in Section 4.

4. Who May Receive My Information, and Why

Recipient: jscreen.org, Inc., a nonprofit organization, and its affiliates (together, "**jscreen**"), and jscreen's partners.

Purposes: (1) to manage my participation in the Program, including providing me with Program resources, additional testing or research opportunities, and follow-up related to my results, including educational materials I may choose to share with my relatives; (2) to send me follow-up surveys about my experience and any actions I took after testing; (3) to evaluate and improve the Program and measure its public health impact; (4) to determine my eligibility for and administer any financial assistance I request, including the related insurance and payment information; (5) to prepare de-identified or aggregate reports and publications that do not identify me, and (6) to use my identifiable information, including any genome sequence data, and any remaining sample of mine and the data derived from it, in research about genetic disease, reproductive carrier screening, hereditary cancer, and their prevention, including in a research registry maintained by jscreen.org.

I understand that jscreen's use of my information may lead to discoveries or products with commercial value, and I will not be paid for the use of my data or share in any

such value. This is also my consent to research use of my genetic information and sample under applicable state genetic privacy laws.

5. My Rights

Right to revoke. I may revoke this authorization, in whole or in part, at any time by sending a written notice to the EOG Privacy Officer at Privacy@EyeOnGenetics.com or 3225 Cumberland Boulevard SE, Suite 540, Atlanta, GA 30339, or to jscreen at privacy@jscreen.org or 5115 New Peachtree Road, Suite 202A, Atlanta, Georgia 30341-3326. A revocation does not apply to information already disclosed or actions already taken in reliance on this authorization. For uses under Section 4, parties may continue to use information already received to the extent necessary to protect the integrity of the research, but will not obtain new information from the Clinical Providers after receiving my revocation. If I revoke this authorization, I may no longer be able to participate in the Program or use jscreen's systems to access testing, but my revocation will not affect any genetic counseling or testing the Clinical Providers are already providing to me.

Conditions. The Clinical Providers will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I sign this authorization.

Redisclosure. jscreen is not a HIPAA covered entity and its affiliates and partners may not be subject to HIPAA. Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy law. jscreen will protect information it receives as described in the jscreen Privacy Policy, including its commitments regarding genetic information. State law may restrict further disclosure of genetic information.

No payment. Neither the Clinical Providers nor jscreen will receive payment from anyone in exchange for the disclosures described in this authorization.

Copy. I will receive a copy of this signed authorization, and I can download or print it from my account.

Expiration. This authorization expires ten (10) years after the date of signature, unless sooner revoked.

6. Age Requirement

The Program is available only to individuals who are at least 18 years of age (or the age of majority in their state, if higher). This authorization may be signed only by an adult patient or by the Authorized Representative of an adult patient. If I am under 18 and believe I need jscreen's services, or if I am a parent, legal guardian, or other person legally authorized to act for someone under 18 who I believe needs them, I may contact jscreen at **info@jscreen.org** or (678) 729-9104 for more information.

7. Signature

I have read this authorization, or had it read to me, and I understand it. I authorize the uses and disclosures described in it.

Electronic signature and records:

If I am agreeing to and signing this authorization electronically, I understand that, by signing and/or by checking the acknowledgment box and taking the steps directed on that page, I am legally signing this authorization and my electronic signature has the same effect as a handwritten signature. I consent to use electronic records and signatures for this authorization under the federal Electronic Signatures in Global and National Commerce Act and applicable state law. jscreen will record the date and time of my signature and related information (such as my account and device information) to verify it, and will keep a copy of this authorization as signed with my records. I understand that I may withdraw my consent to electronic records by contacting jscreen, but doing so will not affect the validity of my signature on this authorization.

If signing in person:

Signature of patient: _____

Date: _____

Printed name: _____

If signed by an Authorized Representative:

Name: _____

Relationship to patient:

☐ legal guardian ☐ health care agent ☐ other: _____

Basis of authority: _____