Under the Health Insurance Portability and Accountability Act ("HIPAA") information about your personal health, including individually identifiable information that relates to past, present, or future health care or payment for health care (also referred to as protected health information or "PHI"), is subject to privacy and security rules. Please provide your consent for the use of your testimonial about participating in the Everyday Wellness Program, a component of The Charles Schwab Group Life, Accidental Death & Dismemberment, Death Benefit, Medical, Dental and Vision Plan (the "Plan"), for Schwab local wellness newsletters, emails, and the HealthCheck360° Monthly Newsletter that will be posted on the Schweb and emailed to Schwab employees, by completing the attached **HIPAA Authorization** below and the **Photo Release Waiver(s)**, if your photo includes your spouse and/or minor dependents.

Your participation is voluntary and will not impact your benefits or eligibility for benefits. Also, information used in the testimonials will not be used by Schwab for employment purposes.

In your testimonial, please do not discuss information regarding mental health issues, substance abuse, contagious diseases or other sensitive issues. Do not discuss the health of your spouse or other dependents.

HIPAA AUTHORIZATION

I authorize the Plan to disclose my PHI, including individually identifiable information that I provide in my testimonial about the wellness program that relates to my past, present, or future health care or payment for health care, in Schwab local newsletters, emails and the HealthCheck360° Monthly Newsletter and on the Schweb for the purposes of explaining the benefits of the Everyday Wellness Program to other Schwab employees.

I understand that:

- I have the right to revoke this authorization at any time for future disclosures the Plan may make, unless the Plan has taken action in reliance upon this authorization. I must revoke this authorization in writing to directly to the Plan.
- The Plan may not condition my treatment, payment, enrollment, or eligibility for benefits upon whether I sign this authorization.
- Once my information has been disclosed, as permitted under this authorization, it may no longer be protected under the federal privacy regulations of HIPAA, so there is a possibility that the party to whom my information is being disclosed may re-disclose the information.

This authorization expires two years from the signature date below or upon my revocation, if earlier.

_____ _____

Signature* Date*

* Indicated required information