EYEGAZE INC.

10363 Democracy Lane,
Fairfax Virginia, 22030
Eyegaze Inc. U.S.A
Phone: 703-385-8800

Authorization for Release of Information

Identifying Information:

Name: _____ Date: _____

Address: _____

Contact Person: _____ Phone: _____

This authorizes the release of any medical or other information necessary to determine and obtain benefits payable for an Eyegaze Edge to Eyegaze, Inc., my insurance carrier or other medical entity. A copy of this authorization will be sent to the Centers for Medicare and Medicaid Services (CMS), my insurance company or other entity of requested. The original authorization will be kept on file by the organization.

The following is a listing of the person(s) and/or organization(s) that I authorize to receive my personal health information pertaining to the acquisition of the Eyegaze Edge. I understand if the person(s) and/or organization(s) listed below are not health care providers, a health plan or a health care clearinghouse, they are not subject to the same Federal privacy rules and they may disclose my health care information without obtaining my permission.

Eyegaze Inc.

_____

_____

_____

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices, Patient Rights, and a copy of the DMEPOS Standards. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

This authorization may be revoked in writing by the above individual at any time.

Printed Name of Parent/Guardian/User: _____

Signature of Parent/Guardian/User: _____ Date: _____

Relationship to Device User: _____ Authority: _____

Please sign, date and return to:

Eyegaze, Inc.
10363 Democracy Lane
Fairfax, VA 22030
Attn: Funding Department

For questions regarding this or any of the forms or for general questions about funding for an Eyegaze Edge, please call us at 703-385-8800.