Accord Healthcare, Inc.
CCPA Authorized Agent Designation

California residents have the right to designate an authorized person or corporate entity to exercise rights granted to them under the California Consumer Privacy Act ("CCPA"). To make this designation, California residents must complete and submit this form to privacyaccordus@intaspharma.com. Incomplete forms or forms without proper signature will not be accepted. Authorized agents that have been provided a power of attorney pursuant to California Probate Code sections 4000-4465 may submit their documentation directly without completion of this form.

I. Consumer Information

Your Full Name: _____

Your Date of Birth: _____

Your Shipping Address on File: _____

Your Email Address on File: _____

Your Phone Number (*with Area Code*): _____

II. Authorized Agent Information

If a natural person will be your authorized agent, please complete section A. If a business will be your authorized agent, please complete section B. The business must be registered with the California Secretary of State and in active standing:

A. Natural Person

Agent's Full Name: _____

Agent's Physical Address: _____

Agent's Email Address: _____

Agent's Phone Number (*with Area Code*): _____

B. California Business

Agent's Business Name: _____

Agent's Business Address: _____

Agent's Email Address: _____

Agent's Phone Number (*with Area Code*): _____

California Secretary of State Registration Number: _____

III. Scope

A. I authorize my Authorized Agent to request the following (*check only one*):

□ Access Request Only □ Deletion Request Only

□ Both Access & Deletion Requests

B. Authorizations are valid for one (1) year from the date of signature if no termination date is listed. Authorizations can be terminated at any time by contacting privacyaccordus@intaspharma.com.

Authorization Termination Date: _____

C. For Access Requests, my non-medical personal information should be sent to the following:

Email Address: _____

IV. Consumer Authorization

I authorize_____(*agent name must match above*) as my agent for the sole purpose of submitting a verifiable consumer request under CCPA. This agent is permitted to request on my behalf that Accord Healthcare, Inc. disclose and/or delete my personal information that is subject to the CCPA as indicated above. I understand that Accord Healthcare, Inc. may contactme to verify my identity and/or authorization. I certify (or declare) under penalty of perjury that the foregoing is true and correct:

Your Signature (Consumer)	**Today's Date** (*MM-DD-YYYY)*
Your Printed Name (Consumer)	