Perspective3

Patient Authorization- *Demonstration*

Patient Name: _____ Patient DOB: _____

Information Disclosure- I have read the below and understand the Patient Authorization and I agree to allow my information (as defined in Patient Authorization) to be used and shared as described in Authorization.

Patient Signature: _____ Date: _____

Program Enrollment- By signing below, I agree to enroll in the Patient Support Program.

Patient Signature: _____ Date: _____

By signing the Patient Authorization, I authorize my healthcare providers, including the pharmacies I use, and my health insurance plan(s) to disclose my personal information, including information about me (eg, my name, address) and my health, including my finances, insurance, prescriptions, pharmacy fills/claims, and medical condition ("My Information") to Company (the manufacturer of PRODUCT® and its affiliates, agents, and contractors, including the administrators of the Company Patient® Support Program, the dispensing pharmacies of Company products, and any other person or entity assisting Company in the administration of the Patient Program (collectively, the "Company Patient Team"), for the purposes listed below:

1. To investigate, verify, and determine my insurance coverage for PRODUCT
2. To provide financial assistance, and support to facilitate access to PRODUCT
3. To facilitate a voluntary training session educating on device use and successful treatment initiation
4. To determine my initial and continuing eligibility for other assistance programs
5. To contact me by phone, mail, e-mail (if my e-mail address was provided), cell phone, or text message (if my cell phone was provided) to request further information, discuss the application process, administer the Program, evaluate treatment progress and/or the effectiveness of the Program, and to conduct market research
6. For Company's internal business purposes of continuous improvement, including ongoing quality control
7. To help ensure the accuracy and completeness of my applications
8. To send me marketing information, offers, and educational materials related to PRODUCT

I understand that my pharmacy provider may receive remuneration from Company in exchange for the health information provided and/or for any therapy support services provided to me. I also understand that once My Information has been disclosed under this Authorization, federal privacy laws may no longer protect it and that it may be subject to further disclosure. I specifically authorize the Company Team to use and disclose My Information for the purposes listed above. I further understand that if I decline to sign this Authorization, that will not affect my eligibility for health plan benefits and treatment by my healthcare providers, but I will not have access to the education and services available through the Patient Support Program. I understand that I may revoke this Authorization at any time by calling 1-800-555-4465 or writing to Company. If I do revoke this Authorization, the Company Patient Team will stop accessing, using, and disclosing My Information thereafter, but the uses and disclosures previously made in reliance on the Authorization will not be deemed invalid. This Authorization expires ten (10) years from the date of my Program Enrollment signature on page 1, unless specified or mandated to be shorter by applicable state law. I understand that I am entitled to a copy of this Authorization once signed.