Patient Authorization to Use and Disclose Health Information

Return completed form by:

Fax: 1-866-876-8966

Mail: P.O. Box 160, Mission, KS, 66201

Email (preferred): ospmanufacturerhipaa@optum.com

1. What information about me will be used and disclosed?

My personal information will be disclosed, including:

- My name, address, date of birth and other identifiers
- My medical information and records, including information about my health condition, medications, test results, and treatment
- My financial information, including information about my insurance
- Other personal information collected about me that is relevant to the purposes described below

2. Who will disclose, receive, and use my information?

By signing this form, I authorize my doctors, pharmacists, and other health care providers ("Providers") and my health plans and health insurers ("Insurers") to disclose my personal information to pharmaceutical manufacturers, patient support programs, hub programs, and authorized agents of manufacturers or programs. These recipients may also share my information with my Providers and Insurers to determine if I am eligible for or enrolled in other plans or programs.

3. What is the purpose for the use and disclosure of my information?

I authorize the use and disclosure of my personal information for the following purposes:

- Operating and administrating medication access programs, including co-pay assistance programs
- Coordination of prescription fulfillment through pharmacies
- Medication adherence and compliance programs
- Other purposes related to patient care and access or similar activities

If I check here, I also authorize the use and disclosure of my personal information for marketing purposes, including contacting me about educational opportunities or other services I may be interested in. I understand that this is optional.

4. When will this authorization expire?

This authorization will expire after 3 years, when I revoke (cancel) it, or as required by state law, whichever comes first.

5. What else should I know?

- My Providers and Insurers may receive remuneration (payment or other compensation) in return for disclosing my personal information.
- Once my information is disclosed, federal privacy laws will no longer protect my information. The people who receive my information may further disclose my information to other parties.
- If I choose not to sign this authorization, my current treatment and my payment, enrollment, or eligibility for benefits will not be affected. However, if I choose not to sign, I may not be eligible for additional programs from manufacturers or other entities.
- I have the right to receive a signed copy of this authorization upon request.
- I can revoke (cancel) this authorization at any time by requesting in writing that it be revoked, using the contact information listed below. However, if my information has already been used or disclosed based on this authorization, those uses and disclosures will not be affected by my choice to revoke (cancel) this authorization.

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* Indicates a required field

Patient Full Name (please print): *

Patient / Parent or Guardian: *
Patient
Parent/Guardian/Personal Representative

Patient/Parent or Guardian Name (If patient under 18 years of age) (please print): *

Description of Relationship to Patient:

Patient Date of Birth (mm/dd/yyy):*

Patient Phone Number with Area Code:*

Additional Parent or Guardian Name (if patient under 18 years of age) (please print):

Description of Relationship to Patient:

By signing below, I am consenting to the use of my Protected Health Information as described above.

Patient/Parent/Guardian/Personal Representative Signature *

Date*

Additional Parent/Guardian/Personal Representative Signature

Date

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