Maxor™

AUTHORIZATION TO USE AND DISCLOSE PHI

| Patient Identification (please print) |
| --- |
| Patient Name: _____<br>(First) (Middle) (Last)<br>Date of Birth: _____ Contact Phone Number: _____<br>Address: _____<br>_____ |

By signing this authorization, I authorize my health insurers, health care providers, pharmacy providers, and their service providers and contractors ("Health Team") to disclose, and I consent to the release of, my personal information, including information about my insurance coverage, prescriptions, medical conditions, health, financial and other information including my Protected Health Information ("PHI") as that term is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended, to Hemangeol Reimbursement Support Services, its representatives, agents, and contractors (collectively "Hemangeol Support") for the purposes described below. I understand that my information, including my PHI, will be disclosed to Hemangeol Support and used for the following purposes: (1) to determine my eligibility for Hemangeol coverage; (2) to obtain any required Hemangeol insurance coverage authorizations, (3) to communicate with my health care providers, including pharmacy providers, and me about my medical care; (4) to facilitate the provision of Hemangeol by pharmacies; and (5) other purposes necessary to carry out the Hemangeol Support operations. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal or state law. I also understand that: (1) I do not have to sign this authorization and my health care providers and insurance company will not require me to sign this authorization in order to provide me with medical treatment or insurance benefits; (2) if I do not sign this authorization, I will not be eligible to receive assistance through the Hemangeol Support; (3) I have a right to receive a copy of this authorization; (4) I may be contacted by Hemangeol Support as part of the assistance process; and (5) I may cancel or revoke this authorization at any time by calling the Hemangeol Support toll-free number 833-386-7623, or by mailing a letter requesting such cancellation to Hemangeol Reimbursement Support Services at [1730 S. Federal Hwy, Suite 273, Delray Beach, FL 33483]; but that this cancellation will not apply to any information already used or disclosed; and (6) I may call Hemangeol Support at any time. This authorization expires one (1) year from the date signed below. I have read this authorization and agree to its terms.

Patient or Legal Representative's Signature: _____

Legal Representative's Name and Relationship: _____

Date of Signature: _____