Dear Patient:

Aureus Pharmacy may be able to assist you with access to patient support services provided by third parties. Support services may include but are not limited to copay cards, free drug programs, access to limited drugs, medication therapy management, reimbursement assistance, or disease-based support programs. These services may be provided by third parties independent from Aureus like pharmaceutical manufacturers, nonprofit foundations, or other outside companies.

For Aureus to provide assistance to you in identifying appropriate financial and/or support services provided by third parties, Aureus will need to review, use and disclose your protected health information (PHI) to certain third parties. We have received your verbal consent and now seek, for our recordkeeping purposes, to obtain your written authorization.

You are not required to agree to this Authorization. However, failure to provide this Authorization will prevent Aureus from assisting you in obtaining assistance that you may need from third parties. You will receive a copy of the Authorization you sign.

Please review this Authorization carefully. If you have any questions regarding this Authorization, please contact Aureus at (844) 428-7387.

Sincerely,

Aureus Pharmacy

Aureus complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. If you speak another language, language assistance services, free of charge, are available to you. Call 1-866-367-2627.

Aureus cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-367-2627.

Aureus 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 *1-866-367-2627.*

Enclosure: See Patient Authorization and Notice of Release of Information Form located in the Company Addressed Stamped Envelope enclosed in the Welcome Packet. Sign and return with the other enclosures.

HIPAAAuthorizationPatientAssistance102716
Approved: 102716

PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION

I. INFORMATION TO BE USED AND DISCLOSED

This Authorization permits Aureus Health Services, LLC and its affiliates (collectively, "Aureus") to use and disclose my medical records and financial information, including but not limited to my diagnosis, medications, and personal information, e.g., name, address, social security number, health insurance information, if any, and household and income information. All or parts of this information may be considered protected health information ("PHI").

In addition, I authorize the release of any of the following information by initialing below:

______ Mental health records*

______ Communicable diseases

______ Alcohol/drug abuse treatment

______ HIV/AIDS Related Information

* This form may not be used to release both psychotherapy notes and other types of health information. A separate form must be used for release of psychotherapy notes.

II. PERSONS AUTHORIZED TO DISCLOSE INFORMATION

By signing this Authorization, you authorize Aureus to disclose the information described in Paragraph I.

III. PERSONS TO WHOM DISCLOSURE MAY BE MADE

Aureus may disclose the information identified in Paragraph I to third parties who provide patient support services, including but not limited to copay cards, free drug programs, access to limited drugs, medication therapy management, reimbursement assistance or disease-based support programs. These third parties may be nonprofit foundations, companies engaged to administer copay card programs, patient assistance or free drug programs, or pharmaceutical manufacturers or companies affiliated with pharmaceutical manufacturers.

IV. PURPOSE

Your PHI may be used for the purpose of obtaining patient support services, including but not limited to copay cards, free drug, medication therapy management, reimbursement assistance, or disease based support programs as

Administered by those identified in Section III. Such financial assistance may include covering co-payments or full or partial costs of my treatment.

V. EXPIRATION DATE

This Authorization will be effective, unless revoked by me in writing, until one year from the date of this Authorization.

For **California residents**: this Authorization expires on ___________________, 20____.

VI. NOTICES

I understand that once PHI is disclosed pursuant to this Authorization, there is no guarantee under federal law that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of Aureus's treatment of me.

I understand that this Authorization will remain in effect until it expires as described above or I provide a written notice of revocation via mail to Aureus Health Services, 300 Merchant Lane, Suite 305, Pittsburgh, PA 15205, or via fax to (844) 228-7387. The revocation will be effective immediately upon Aureus's receipt of my written notice, except that the revocation will not affect any disclosures by Aureus or others referenced in this Authorization in reliance on this Authorization before Aureus received my written notice of revocation.

VII. SIGNATURE

I have read and I understand the terms of this Authorization, and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the use and/or disclosure of my health information in the manner described above.

____________________________	___________________________________	_________
Patient's Name	Signature of Patient or Representative	Date

_________________________________	____
Description of Representative Authority	Address of Patient

Patient's Date of Birth: __________

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