PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION
Solution Center / Cardinal Health
3060 Ogden Ave Ste 200 Lisle, IL 60532

I, _____, allow my doctor(s), my health plan or insurers, and any other health care providers to give to Cardinal Health, the administrator of the Solution Center, all medical information relating to my treatment with Euflexxa®.

This information may include spoken or written facts about my medical condition or health insurance benefits. It may include copies of records from my health care providers or health plans outlining my medical history or treatment plan. All of this information may be considered protected health information (PHI).

The Solution Center will use and give out this information to help find ways to pay for Euflexxa® and for proper management and administration of the Solution Center. The PHI may also be disclosed to and/or used by the sponsor of the Solution Center, Ferring Pharmaceuticals, biopharmaceutical manufacturers, as well as other companies involved with manufacturing or distributing the Euflexxa® product as needed to run the Solution Center.

I know that people who work for and with the Solution Center and its sponsor, Ferring Pharmaceuticals, may use and receive my information, but they may use it only as allowed in this form. I understand that the Solution Center will keep my information private and use and disclose it only as allowed on this form. I understand that, once it is disclosed, it may be further disclosed by the recipient(s) and federal privacy laws will not protect it if the entities receiving the information are not subject to those laws.

This Authorization will last for 5 years after the date I sign this form. If I change my mind before that time and want to stop participating in this program, I can tell Cardinal Health, by writing to the address on this form, that I want to cancel this Authorization. I understand that I cannot cancel any actions that have already been taken by relying on this Authorization.

I know that I may refuse to sign this form. My choice about whether to sign this form will not change the way my health care providers treat me. I understand that the Solution Center does not promise to find ways to pay for my Euflexxa,® and I know that I am responsible for the costs of my care. I agree that a copy of this form may be treated as a signed original.

Patient Signature: _____ Date: _____
If the patient cannot sign, the patient's representative must sign below:

By: _____ Date: _____
(Signature of person signing for patient)
Describe relationship to patient and right to act for patient:

(Provide a copy of this form to the patient.)