Dear Patient:

Aureus Health Services 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, patient assistance, free drug programs, access to limited drugs, and medication therapy management. 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. By law, only with your prior written authorization may Aureus disclose your PHI to these third parties. As soon as we obtain your prior written authorization, we will work to assist you with accessing such services.

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 Health Services

Enclosure

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, patient assistance, free drug programs, access to limited drugs, medication therapy management, financial assistance or reimbursement. 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, patient assistance, free drug, medication therapy management, financial assistance or reimbursement, and/or participation in

a reimbursement assistance or patient financial assistance program 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, 305 Merchant Lane, 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