CHIESI

CAREDIRECT™

Service Request Number: _____

PATIENT AUTHORIZATION FORM

You have expressed an interest in Pertzye® (pancrelipase) or Bethkis® (Tobramycin Inhalation Solution) therapy. The Chiesi CareDirect™ Program can provide certain services to you and on your behalf during the search for Pertzye or Bethkis therapy reimbursement, and during your therapy. The Chiesi CareDirect Program is an agent of Chiesi USA, Inc.

In order to provide these Services, Chiesi CareDirect will need to use your health information (called "Protected Health Information" or "PHI"), and to share it with your health plan and the pharmacy that will receive your doctor's prescription. This authorization will allow your healthcare providers, health plans, and health insurers that maintain PHI about you to disclose your PHI to Chiesi CareDirect so that the Support Center may provide these Servicers to you, or on your behalf.

Authorization and Signature:

By signing this Authorization, I authorize my health plans, physicians, health care professional, hospital, clinic, pharmacy or other health care provider to disclose my personal health information, including but not limited to, information relating to my medical condition, treatment, care management and health insurance, as well as all information provided on this form and any prescription ("Personal Health Information"), to Chiesi, its affiliates and their representatives, agents and contractors for the following purposes, including but not limited to investigating insurance coverage, fulfilling and coordinating delivery, assisting with product training, providing product support; and any internal use by Chiesi. I understand that my information disclosed under this authorization may be re-disclosed by Chiesi and no longer protected by federal or state privacy laws. I understand that I may refuse to sign this authorization, and my treating providers and health plans may not condition current or future treatment, payment, or eligibility for benefits on my provision of this authorization. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at anytime by mailing a letter requesting such cancellation to Chiesi CareDirect, 6931 Arlington Rd, Suite 308, Bethesda, MD 20814, but that this cancellation will not apply to any information already used or disclosed through this Authorization. This Authorization expires five (5) years from the date signed below.

Patient Printed Name: _____

Signature: _____ Date: _____

Phone #: _____

If you are signing this Authorization as a personal representative of the person to receive Pertzye or Bethkis therapy, please state your relationship (e.g. "legal guardian"):

Describe Authority to Sign for the Patient: _____

Please fax signed form to (866) 410-6241
For questions, please call
***Chiesi CareDirect* toll-free at (888)-865-1222**

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Pertzye® is a registered trademark of Digestive Care, Inc.

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