saizen®
[somatropin (rDNA origin) for injection]

connections for growth®
Ph: 800-582-7989
Fax: 877-408-4288

Patient Authorization

Patient's Name _____

Address_____

Home Phone _____

E-mail Address (optional)_____ DOB ____/_____/_____

Authorization to Use and Disclose Health and Other Personal Information

I authorize my physician and his/her staff to disclose my health and other personal information, including, but not limited to, the information on this form, to EMD Serono, Inc. and its agents and representatives (collectively "EMD Serono") so that EMD Serono may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to:

(1) facilitate the filling of prescription for and the delivery and administration of Saizen® [somatropin (rDNA origin) for injection];

(2) assist me in obtaining insurance coverage for Saizen®

(3) Contact me by mail, e-mail, and/or telephone to enroll me in, and administer, programs that provide Saizen® support services;

(4) provide me with free educational information and materials;

(5) conduct surveys to measure my satisfaction with Saizen® and Saizen® support services; and

(6) contact me about participating in clinical trials and market research.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to EMD Serono in order to assist EMD Serono in accomplishing the purposes described above.

I understand that once my information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws (the Health Insurance Portability and Accountability Act) or state privacy laws and may be further disclosed to others. However, I understand that EMD Serono will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent.

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive Saizen®, but it will limit my ability to receive support services for Saizen®.

PATIENT MUST SIGN THE BACK OF THIS FORM THEN SEND OR FAX BOTH PAGES

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I understand that this authorization will remain in effect for ten years from the date of my signature, unless I revoke it earlier by contacting EMD Serono Director of Patient Support Services, Department of Endocrinology in writing at One Technology Place, Rockland, MA 02370. If I revoke this authorization, EMD Serono will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I understand that the services provided by EMD Serono that are described in this authorization can be changed at any time, without prior notification.

I understand that certain Third Parties may receive compensation in exchange for their disclosure of my information to EMD Serono.

I also understand that I have the right to receive a copy of this authorization.

Patient name (please print): _____

Signature of patient (or personal representative): _____ Date: _____

Authority/relationship of personal representative (if applicable)_____

Signature of patient (or personal representative): _____ Date: _____

Authority/relationship of personal representative (if applicable)_____