PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION (PAN)

Nutropin gps™

Phone: (866) 688-7674 **Fax:** (800) 545-0612 **Nutropingps.com**

We work to help you pay for your Genentech product. We can help in many different ways. We assist people who have a health care plan as well as those who don't.

If you don't have a health care plan, or your plan won't pay for your Genentech products, we might be able to help. If you meet certain financial and medical standards, we can supply free medicine. This is done through the Genentech® Access to Care Foundation (GATCF).

For us to help, we need to look at, use and disclose your personally identifiable information (PII). Your health care provider and health care plan can disclose your PII to us only with your written authorization. By signing this authorization form, you are authorizing your health care provider and health care plan to release your PII to us, and authorizing us to disclose your PII as necessary to perform services for you. Once you sign this form and it is sent back to us, or submitted electronically by you or by your health care provider on your behalf, we can start to provide these services. You can choose not to agree to this authorization, however, please note that we cannot provide our services without it. This means you might need to pay for certain medications on your own.

PLEASE READ THROUGH THIS FORM CAREFULLY. IF YOU HAVE ANY QUESTIONS, TALK TO YOUR HEALTH CARE PROVIDERS' OFFICE OR CALL US AT THE PHONE NUMBER LISTED AT THE TOP OF THIS PAGE.

1. Information To Be Disclosed Or Used

This signed form lets my health care providers and health care plans send my PII and this form electronically, to Nutropin GPS and/or GATCF. This includes:

- All my health records relating to my treatment
- Information about my health care plan benefits
- The dollar balance left on the total of the lifetime payments covered by my health care plan policy (if this applies to my plan)
- Any information having a bearing on my health or my adherence to my treatment

All of the above is considered part of my PII. I know this could include information about:

- Sexually transmitted diseases
- Mental health conditions
- Genetic test results

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2. Who May See And Use Personally Identifiable Information (PII)

My PII may be seen by Nutropin GPS and/or GATCF. These are programs sponsored by Genentech. Its address is 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990.

It may also be seen by anyone helping Nutropin GPS perform services including Genentech employees and any of Genentech's partners, for the purpose of facilitating access to Genentech products. Genentech may share your PII with partners, and/or their agents and affiliates, and your health care provider and health plan.

My PII May Be Used Only In These Ways:

- Helping with my health care plan coverage for Genentech products
- Applying to GATCF
- Determining eligibility for alternative forms of coverage and sources of funding
- Coordination of prescription fulfillment through a pharmacy
- Tracking my use of Genentech products
- For Genentech, or our partners' administrative purposes

3. Notices

This authorization and notice of release shall be in effect for five years from the date of my signature unless a shorter period is required by state law.

I understand that if I am a resident of the state of Maryland, this authorization will be valid for no longer than 1 year from the date I signed it.

Once I sign this form, I know my PII might not be covered by any federal law that restricts the use and disclosure of my PII. There is no guarantee my PII might not be released to a third party. This third party might not need to follow the conditions of this authorization and notice of release.

I know I can refuse to sign this form. I may withdraw authorization at any time and for any reason. This won't affect the start or continuing of my treatment, the quality of my treatment, and will have no impact on my treatment by my health care provider. To withdraw it, I must send a written notice to Genentech. It can be sent by fax or by mail to the address on this page. This withdrawal goes into effect once it is received by Genentech. If I don't sign this form or if I withdraw my authorization, Genentech will not be able to help me with access to my Genentech product(s).

I understand that I, as the patient or signer, have a right to obtain a copy of this signed authorization and notice of release during the time period this authorization is valid, or up to three years after it is signed.

4. Distribution Acceptance

If I receive free product from GATCF, I will use Genentech products as my health care provider has prescribed them to me. I will not sell or distribute Genentech products. I understand it is unlawful to do this. I am responsible for ensuring any Genentech product is sent to a secure address when it is shipped to me. I know it is my duty to control any Genentech product while it stays in my possession.

SECTION 5 ON THE NEXT PAGE IS REQUIRED.

This written notice must be signed, dated, and mailed, faxed, or electronically submitted to:

Nutropin GPS™
PO Box 220039
Charlotte, NC 28222-0039

Fax: (800) 545-0612

Phone: (866) 688-7674
Fax: (800) 545-0612
Nutropingps.com

Nutropin gps™

5. Signature And Date (REQUIRED)

I have read this document or have had it explained to me. By signing this form, I know I am authorizing the release and disclosure of my PII as discussed in this authorization form. **(Please fill in all information below. Be sure to sign and date this authorization. If you don't, it could hold up the process for helping you.)**

You must sign and date here

Signature of Patient or Legally Authorized Person _____ Relationship to Patient _____ Date Signed (mm/dd/yy) _____

Print Patient's Name _____ Patient/Alternate Contact Address _____

Legally Authorized Person / Alternate Contact Name _____ Contact Phone _____

❑ OK to leave a detailed message: I authorize Nutropin GPS/GATCF to leave a detailed message at the following number:*_____.

*I understand this message may include personal health information, including but not limited to, the name of the medication I have been prescribed, my doctor's name, and details regarding insurance coverage

6. Financial Information (GATCF only)

TOTAL HOUSEHOLD INCOME FOR THE PREVIOUS CALENDAR YEAR: $ _____

Read the following Attestation: I understand that to qualify for free medicine, GATCF has criteria that must be met, including income. I certify the above statement of my total annual household income for the previous calendar year is true, and I do not have the financial resources or insurance coverage to pay for Genentech products. I know that GATCF could ask me for a copy of my IRS 1040 form or other proof of income for the purpose of an audit. I agree to provide my financial documentation in a timely manner, if so requested. In addition, I will notify GATCF immediately if my insurance situation changes. Please note that GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the financial attestation is false or inaccurate. By signing this attestation, I certify that the above statement of my annual household income amount is true and accurate, to the best of my knowledge.

Sign and date here (required for GATCF enrollment)

Signature of Patient or Guardian _____ Date Signed (mm/dd/yy) _____

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