PATHWAYS 360℠
Patient Authorization

In order to receive PATHWAYS 360℠ services, you must complete this Authorization to share Protected Health Information. Please note that you do not need to complete this authorization to start any Dyax product(s). You may:

- **fax this completed form to PATHWAYS 360 at 1-888-806-4829, or**
- **call PATHWAYS 360 at 1-888-452-5248 for instructions on how to sign this form electronically**

Authorization to Disclose Protected Health Information

Some of the information that PATHWAYS 360 needs to obtain from my health care provider(s) and health plan(s) about me, such as my name and address, my health insurance benefits, prescription drug coverage and drug and medical information, including medical conditions, treatment and drug history, is "protected health information". The collection, use and disclosure of such protected health information is protected under federal and some state privacy laws. In order for PATHWAYS 360 to provide me with the services described in the PATHWAYS 360 services overview, the PATHWAYS 360 staff may need to obtain from my health care provider(s) and health plan(s), the protected health information about me described above.

By signing the PATHWAYS 360 Patient Authorization, I authorize my health care providers (such as my doctor and pharmacies and pharmacists) and health plan and/or health insurer to disclose protected health information about me to Dyax Corp., PATHWAYS 360, and the companies working with it to provide the PATHWAYS 360 services (hereafter collectively referred to as "PATHWAYS 360") so that it may use this information as necessary to assist with:

(1) researching insurance coverage for any Dyax product(s)

(2) helping to arrange financial assistance to help me pay for my Dyax product(s) treatment by contacting my insurer, other potential funding sources, social workers, patient advocacy organizations, or patient assistance programs on my behalf in order to determine if I am eligible for other financial assistance

(3) coordinating delivery and administration of Dyax product(s) to my designated treatment site(s)

(4) providing educational and support services and materials related to Dyax product(s) treatment, including, if applicable, coordinating with an infusion service provider and/or Clinical Nurse Educator that is providing educational services to me

(5) collecting information related to treatment with Dyax product(s) to assist in the coordination of care

(6) providing me with information related to Dyax product(s) and hereditary angioedema or to contact me by mail, email, text, telephone and/or any alternative communication method to ask me about my experiences with, or thoughts about, products, services and programs that PATHWAYS 360 or Dyax Corp. offers or sponsors, and to help Dyax Corp. develop new products, services and programs. I understand that the companies working with Dyax Corp. to provide PATHWAYS 360 receive compensation for the services that they provide, including the service of contacting me to discuss products and services.

I understand that PATHWAYS 360℠ receives compensation for the services it provides, including the services of contacting me to discuss products and services.

I understand that information disclosed pursuant to this Authorization may be subject to redisclosure by PATHWAYS 360 and no longer be protected by federal privacy regulations.

I understand that my healthcare professionals, health plans, and health insurers may not condition treatment, payment, enrollment in a health plan, or eligibility of benefits on whether or not I sign this authorization. I acknowledge, however, that PATHWAYS 360 may not be able to provide me with full PATHWAYS 360 services described above unless PATHWAYS 360 is able to receive from my healthcare providers, health plans, and health insurers, the protected health information described in this authorization.

I understand that I will receive a copy of this signed Authorization upon request.

I understand that I may revoke this authorization at any time by contacting PATHWAYS 360 (**info@pathways360.com**). My revocation will not apply to protected health information already disclosed by my health care providers and health plans and insurers to PATHWAYS 360 on the basis of this Authorization before they learn that I have revoked it. Unless revoked sooner, this Authorization will expire 15 years from the day it is signed by me as stated below.

I have read and understand this Authorization.

X Patient/Guardian Signature: _____ Date: _____

X Print Patient Name: _____

X Contact Phone Number: (_____) _____-_____

X Patient Date of Birth: _____\ _____\ _____

X Patient Email Address: _____

X Patient Mailing Address: _____