

**AUTHORIZATION FOR THE USE OF DISCLOSURE OF INFORMATION TO  
REGIONAL HEALTHCARE FOUNDATION – PRESCRIPTION DRUG ASSISTANCE PROGRAM**

PARTICIPANT INFORMATION:

Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

**Purpose of Request:** Information obtained by using this Authorization will be furnished to and used by **Regional Healthcare Foundation** to determine my eligibility for participation in the **Prescription Drug Assistance**, a program designed to assist participants in locating prescription drug programs made available by pharmaceutical companies and others whereby participants can obtain their prescriptions for free or below customary market costs and to assist participants in making application to such providers.

**To the Participant:** In order to determine your eligibility for the Project and to administer your participation in the Project, if accepted, Regional Healthcare Foundation will need to obtain certain information about you from your doctor and be authorized to relay this information to the Pharmaceutical company/companies providing patient assistance with free or below market cost medications. **The Regional Healthcare Foundation** agrees that they will only use this information to determine your eligibility for this Project, to administer the Project and to account for your withdrawal if you decide to stop participating in this Project. Please complete this Authorization for the disclosure of information in connection with the Project.

I request and authorize my doctor "Doctor" who is \_\_\_\_\_ and whose address is: \_\_\_\_\_ to release and give to the Regional Healthcare Foundation, including representatives who work on their behalf, information about me and my medical condition, which is necessary to determine my eligibility for the Project if I am accepted. The type of information that may be given under this authorization includes:

- ◆ My name and birth date
- ◆ My address and telephone number
- ◆ Billing information about me
- ◆ Information about my health benefits or health insurance coverage
- ◆ Information on my medical condition, which indicates that the use of the requested medicine is medically necessary.

If my medical record contains information about drug and/or alcohol abuse, mental health or genetic information, I agree that its release to the **Regional Healthcare Foundation** for the purposes above stated.

I authorize the release of my medical records created both before and after the date I sign this Authorization. I understand that I can inspect a copy of the protected health information that is to be used or disclosed.

I understand that I need to sign this Authorization to take part in this **Prescription Drug Assistance Program**. If I do not sign this Authorization, my decision will not affect my ability to obtain assistance from a health care provider of my choice or to seek assistance from other sources.

I understand that I can cancel this Authorization at any time by writing to my Doctor at his/her address as set forth above. If I do so, I will send a copy of this writing to the Regional Healthcare Foundation. If I cancel this Authorization, then my Doctor will stop providing the **Regional Healthcare Foundation** and their representatives with information about me. However, I cannot cancel actions that have already been taken by relying on my Authorization.

I understand that once my Doctor gives **the Regional Healthcare Foundation** information about me based on this authorization, federal privacy laws may not prevent Regional Healthcare Foundation from further disclosing my information and that the Regional Healthcare Foundation, its affiliates', employees, officers, and directors are not legally responsible or liable for the re-disclosure of the information on this Authorization.

I understand that signing this authorization does not guarantee that I will be accepted into any prescription drug assistance program that the Foundations' Prescription Drug Assistance may locate for me.

This authorization will expire one (1) year after the date it is signed, below, or one (1) year after the last date I receive medicine under the Project, whichever is later.

I UNDERSTAND THAT THE FOUNDATIONS PRESCRIPTION DRUG ASSISTANCE PROGRAM IS NOT A SUBSTITUTE FOR MEDICARE PART D PRESCRIPTION DRUG COVERAGE AND IF I DELAY ENROLLING IN PART D, I MAY INCUR A PREMIUM PENALTY.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Dated

\_\_\_\_\_  
Print Participant Name

\_\_\_\_\_  
Authority to sign on the BEHALF of Participant