

East Tennessee Cancer and Blood Center

Dr. A.K. Sen, M.D., M.R.C.P. (U.K.) F.A.C.P.

*1406 Tusculum Blvd, Suite 2000
Greeneville, TN 37745
423-787-7080/423-787-7087*

*110 Corporate Drive, Suite 120
Johnson City, TN 37604
423-282-0534/423-282-2064*

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I agree to permit my health care provider, East Tennessee Cancer & Blood Center (“Provider”), to disclose to the manufacturer and/or distributor of certain biotechnology products, and its contractor together (“Company”), information about me and my medical condition as is reasonably necessary to:

- > Obtain information on insurance coverage and payment for _____ (drug name), and any other product manufactured by Company that may be Prescribed to me during my treatment, and to determine if I may be eligible to Participate in an available patient assistance program.*

In carrying out these activities, company may share the information about me with my health insurers, if any. My health insurers may respond by disclosing information about me and my insurance coverage to Company. Company may share the insurers’ responses with my Provider.

Once my health information has been disclose by my Provider and my health insurers to Company, federal privacy laws may no longer protect the information from further disclosure. However, **Company agrees to protect my information by using and disclosing it only for the purposes described above or as required law.** My health information will not be used or disclosed by Company for any other purpose unless information that identifies me is first removed. These limitations continue even after this Authorization expires (ends) or I revoke (take back) this Authorization. I understand that:

- I do not have to sign this Authorization, but if I don’t, Company will be unable to verify my insurance coverage for Products or determine if I may be eligible to participate in an available patient assistance program.*
- My Provider and my health issuers will not condition my medical treatment, payment for treatment, or insurance benefits on my agreement to sign this authorization. However, **if I do not sign this Authorization, I may have to pay for the Products myself.***
- I may revoke (take back) this Authorization at any time by mailing a certified letter to the above listed address. If I revoke this Authorization, however, company may be unable to assist my Provider in obtaining payment for products or determining if I may be eligible to participate in an available patient assistance program.*

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- *Revoking this Authorization will prevent my provider and my health insurers for further disclosures of my health information to Company after the date my letter of revocation is received and processed by them. However, revoking this authorization will not effect Company's ability to use and disclose any information it has already received.*
- *I am entitled to a copy of this Authorization; expires ten years from the date of my signature.*

Signature of Patient/Legal Representative

Date

Printed name of Patient/Legal Representative

Legal Representative's relationship to Patient