



PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

ProStraCARE™

3060 Ogden Ave Ste 201 Lisle, IL 60532

I, _____, authorize my physician(s), my health plan or insurers, and any other health care providers to give to ProStrakan, Inc., its vendor Cardinal Health*, the administrator of the ProStraCARE™ program, and/or any other affiliated companies, subcontractors, vendors and/or partners(collectively "ProStrakan") that help with my enrollment into and for proper administration of the ProStraCARE™ program in determining coverage for the prescribed ProStrakan product under my current health insurance plan and/or, if applicable, my eligibility for participation in the ProStraCARE™ Patient Assistance Program (the "Program").

This information may include spoken or written facts about my medical condition, my health insurance benefits, name, date of birth, address, telephone number(s), social security number and/or financial information. It may include copies of records from my health care providers or health plans outlining my medical history and my treatments. All of this information may be considered protected health information (PHI).

I authorize ProStrakan, Inc. and Cardinal Health to use and/or disclose my information for the following purposes:

- Determine whether my health insurance benefits will pay for ProStrakan's product;
- Locate a specialty pharmacy for me that can fill my prescription, if applicable, and facilitate dispensing of my prescription by sending my information to that specialty pharmacy;
- Determine my eligibility for participation in the ProStraCARE™ Patient Assistance Program or to help find other ways to pay for those product(s), and for proper management and administration of the program;
- Provide free information and patient educational materials to me about my condition, treatment options, products and/or program offerings;
- Provide me with information about compliance with treatments my healthcare provider has prescribed;

I know that people who work for and with the ProStraCARE™ program and its sponsor, ProStrakan, Inc., may use and receive my information, but they may use it only as authorized in this form or for such purposes as may be required by applicable law. I understand that ProStrakan, Inc. will keep my information private and use and disclose it only as allowed on this form. I understand that, once it is disclosed, it may be further disclosed by the recipient(s) and federal privacy laws will not protect it if the entities receiving the information are not subject to those laws.

This Authorization will last for five years after the date I sign this form. If I change my mind before that time and want to stop participating in the program, I can tell Cardinal Health (the program administrator), by writing to the address on this form that I want to cancel this Authorization. I understand that I cannot cancel any actions that have already been taken by relying on this Authorization.

I know that I may refuse to sign this form. My choice about whether to sign this form will not change the way my health care providers treat me. However, I understand that my refusal to sign this form may not allow me to participate in this program. I understand that the ProStraCARE™ program does not promise to find ways to pay for my medication(s) and I know that I am responsible for the costs of my care. I agree that a copy of this form may be treated as a signed original.

Patient Signature: _____ Date: _____

If the patient cannot sign, the patient's representative must sign below:

By: _____ Date: _____

(Signature of person signing for patient)

Describe relationship to patient and right to act for patient

(Provide a copy of this form to the patient / patient's representative.)

*Cardinal Health refers to Cardinal Health, Inc. and any of its subsidiary companies.