



# PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION

**Phone:** (800) 530-3083 **Fax:** (650) 225-1366

Dear Patient:

The Genentech® Access to Care Foundation was established by Genentech USA, Inc. to help qualified patients who are not able to obtain a Genentech product for financial reasons. If a patient does not have insurance or is deemed uninsured due to denial by private and public payers, and the patient meets certain financial criteria, the Genentech Access to Care Foundation may provide Genentech products free of charge.

In order for Genentech Access to Care Foundation to provide the described services, we will need to review, use and disclose your protected health information (PHI). By law, only with your prior written authorization may your health care provider, health plan or health insurer disclose your PHI to Genentech Access to Care Foundation. As soon as we obtain your prior written authorization, we will work to provide you with the services.

You are not required to agree to this Authorization. However, failure to provide this Authorization may prevent you from becoming eligible for the Genentech Access to Care Foundation patient assistance program, which may result in your need to pay for certain products with your own funds. You will receive a copy of the Authorization you sign.

Please review this Authorization carefully. If you have any questions regarding this Authorization, please contact your health care provider's office. Contact information is included below.

## I. Information to Be Disclosed or Used

This Authorization permits my health care providers, health plans and health insurers who provide services to me to use and disclose to Genentech Access to Care Foundation, its authorized agents and assignees, all medical records and financial information with respect to my treatment that may have bearing on the benefits payable for services or products provided through my health care provider, health plan or insurer under any plan providing benefits or services, including, without limitation, the dollar balance of benefits remaining under any applicable lifetime maximum benefits provisions, or that may have bearing on my medical condition or compliance with therapy. All of this information may be considered PHI, and may, if relevant, include information about HIV/AIDS and/or other communicable diseases, mental health information, and/or information concerning genetic test results.

## II. Persons Authorized to Disclose Information

The PHI identified in Paragraph I may be disclosed by my health care provider, health plan, health insurer or others who may hold my PHI.



### III. Persons to Whom Disclosure May Be Made

The PHI identified in Paragraph I may be disclosed to and/or used by Genentech Access to Care Foundation, their sponsor Genentech USA, Inc., a biopharmaceutical manufacturer located at 1 DNA Way, Mail Stop #210, South San Francisco, CA 94080, and its related entities, their agents or assignees, and certain Genentech business partners, as well as other companies involved in the administration of certain Genentech products.

### IV. Description of Each Purpose

My PHI may be used for the purposes of reimbursement and/or participation in a reimbursement assistance or patient assistance program administered by Genentech Access to Care Foundation. My PHI may also be used for purposes of tracking the general use of a Genentech product, assessing and improving Genentech's reimbursement and patient assistance services, and proper management and administration of Genentech's business.

### V. Expiration Date or Event

California residents only: This Authorization will be effective, unless revoked by me in writing, until December 31, 2015.

All other residents: This Authorization will be effective, unless revoked by me in writing, for up to one year from the date of this Authorization.

### VI. Notices

I understand that once my health information is disclosed pursuant to this Authorization, there is no guarantee under federal law that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my health care provider's treatment of me. If I refuse to sign or revoke this Authorization, however, I may be responsible for costs that may have otherwise been covered by Genentech Access to Care Foundation.

I understand that this Authorization will remain in effect until it expires as described above or I provide a written notice of revocation via mail to Genentech Access to Care Foundation, 1 DNA Way, Mail Stop #210, South San Francisco, CA 94080, or via fax to (650) 225-1366. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider or others referenced in this Authorization, including without limitation, Genentech Access to Care Foundation, in reliance on this Authorization before my health care provider received my written notice of revocation.

## VII. Distribution Acknowledgment

I also hereby state (or my parent/guardian hereby states) that if I should receive free product from Genentech Access to Care Foundation, I will utilize it for the reason that my physician has prescribed it to me. I will not sell or distribute a Genentech product, as I acknowledge it is unlawful to do so. I will be responsible to ensure that any Genentech product being delivered to me will be delivered to a secure address for purposes of receipt of shipment and I understand it is my duty to control any Genentech product while it remains in my possession.

## VIII. Signature

I have read and I understand the terms of this Authorization, and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the use and/or disclosure of my health information in the manner described above.

Print Patient's Name (required)

Signature of Patient or Guardian\* (required)

Description of Authority (required)

Patient's/Guardian's Address (required)

\*If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally).

Date (required)

## IX. Financial Information

- Only uninsured patients (and patients whose insurance has denied treatment) who wish to apply to the Genentech Access to Care Foundation for assistance need to fill out this section.
- There is no need to complete this section if the patient has insurance coverage for the Genentech product in question.

Household Adjusted Gross Income:

\$0-25K/yr

\$25,001-50K/yr

\$50,001-75K/yr

\$75,001-100K/yr

I understand that in order to qualify, my adjusted gross income may not exceed \$100K/yr. I certify that the above statement of my previous year's income is true and that I have no medical insurance coverage for the Genentech product in question, including Medicare, Medicaid or other public programs, and that I have insufficient financial resources to pay for the prescribed therapy. I also agree to furnish my IRS 1040 (or if none, then my Social Security Benefit Statement or W-2) within 45 days of the submission of this form. I understand that failure to provide this documentation may result in an interruption in therapy.

Signature of Patient (complete if applicable)

Date Signed (complete if applicable)