

AUTHORIZATION TO USE AND DISCLOSE MY MEDICAL INFORMATION

By signing this Authorization, I am authorizing CenterWell Pharmacy, Inc. ("CenterWell"), and all of its respective affiliates and subsidiaries ("Receiving Entities") to use and disclose my Medical Information, including my Protected Health Information (collectively "Personal Information"), for the following purposes:

- Provide me information related to my condition and provide disease management support;
- Provide me information about offers and services from pharmaceutical manufacturers and other third parties that may be of interest to me;
- Provide pharmaceutical manufacturers and their affiliates and agents with information about me to allow them to administer applicable pharmaceutical manufacturers' patient support services program, including but not limited to understanding health care providers utilizing services to enhance delivery of educational materials, assessing inventory and dispense data to improve forecasting models for future supply, *and* which may support my pharmacy experience and treatment journey. Such services may include: copayment assistance programs, reimbursement assistance programs, drug coverage verification, nurse educator services, adherence programs; and/or
- Provide me with promotional and informational materials relating to pharmaceutical manufacturers' products and services.
- To permit proper administration of a pharmaceutical manufacturers and their agents' 340B program for a product, when you are obtaining the pharmaceutical manufacturer's product from CWSP." The 340B Program is a federal program created by the United States government that requires manufacturers participating in Medicaid to agree to provide outpatient drugs to certain entities at significantly reduced prices. To implement 340B programs manufacturers require certain data from pharmacies.

The following person(s) or class of person(s) are given permission to receive and use my Medical Information:

- Pharmaceutical manufacturers and their affiliated companies, agents and representatives;
- Service providers managing patient support services and/or maintaining, de-identifying, aggregating or analyzing data for pharmaceutical manufacturers; and/or
- My health insurance plans.

My Medical Information. I understand that my medical information may include my entire medical record and information about my mental health, alcohol and drug abuse, family planning and pregnancy, communicable diseases (like HIV), genetic testing and information, and developmental disabilities.

Remuneration. I am aware Receiving Entities may receive payment or other remuneration from third parties, including pharmaceutical manufacturers, in exchange for obtaining this Authorization and/or making the communications to me that are described in this Authorization.

Right to Revoke Authorization. I understand that I have the right to revoke this authorization, except to the extent that CenterWell has already used or disclosed my Medical Information in reliance of this authorization. To revoke my authorization, I understand that I must call CenterWell Specialty Pharmacy at 1-800-486-2668.

My Information May Be Re-Disclosed. I understand that if my Medical Information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by a person who receives my Medical Information. I understand that this re-disclosure may not be protected by the applicable privacy laws.

I Am Not Required to Sign this Authorization. I understand that I may refuse to sign this authorization without affecting my ability to obtain treatment or services provided by CenterWell.

Right to Receive Copy of This Authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided a copy of this Authorization.

Expiration Date. This authorization will expire one year from the date it was signed or the maximum period permitted under state law, unless I revoke this Authorization at an earlier date.

Yes

No