

Dear Patient,

Meijer Specialty Pharmacy may be able to assist you with access to patient support services provided by third parties. Support services may include but are not limited to copay cards, free drug programs, access to limited drugs, medication therapy management, reimbursement assistance, or disease-based support programs. These services may be provided by third parties independent from Meijer like pharmaceutical manufacturers, nonprofit foundations, or other outside companies.

For Meijer to provide assistance to you in identifying appropriate financial and/or support services provided by third parties, Meijer will need to review, use and disclose your protected health information (PHI) to certain third parties.

You are not required to agree to this Authorization. However, failure to provide this Authorization will prevent Meijer from assisting you in obtaining assistance that you may need from third parties.

Please review this Authorization carefully. If you have any questions regarding this Authorization, please contact Meijer at (855) 263-4537.

Thank you,

Meijer Specialty Pharmacy

Meijer Specialty Pharmacy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-543-3704. 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-543-3704。

Patient Authorization and Notice of Release of Information

I. Information to be Used and Disclosed

This Authorization permits Meijer, Inc., Meijer Stores Limited Partnership, Meijer Great Lakes Limited Partnership, and its affiliates (collectively, “Meijer”) to use and disclose my medical records and financial information, including but not limited to my diagnosis, medications, and personal information, e.g., name, address, social security number, health insurance information, if any, and household and income information. All or parts of this information may be considered protected health information (“PHI”). I understand these records may contain information created by other persons or entities, including physicians and other health care providers.

If I initial the options below, information regarding the use of drug and alcohol treatment services, mental health services, reproductive health services, HIV/AIDS treatment, and treatment for sexually transmitted diseases may be disclosed for the purposes listed in section IV.

In addition, I authorize the release of any of the following information by initialing below:

- Alcohol/Drug Abuse Treatment
- Mental Health Information (except psychotherapy notes*)
- Reproductive Health Services
- HIV/AIDS Related Information
- Sexually Transmitted Disease

* This form may not be used to release both psychotherapy notes. A separate form must be used for release of psychotherapy notes.

**New York: By my specifically authorizing the release of HIV/AIDS related, alcohol or drug treatment, or mental health treatment information that the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at 212-306-7450. These agencies are responsible for protecting my rights.

II. Persons Authorized to Disclose Information

By signing this Authorization, you authorize Meijer to disclose the information described in Paragraph I.

III. Persons to Whom Disclosure May be Made

Meijer may disclose the information identified in Paragraph I to third parties who provide patient support services, including but not limited to copay cards, free drug programs, access to limited drugs, medication therapy management, reimbursement assistance or disease-based support programs. These third parties may be nonprofit foundations, companies engaged to administer copay card programs, patient assistance or free drug programs, or pharmaceutical manufacturers or companies affiliated with pharmaceutical manufacturers.

IV. Purpose

My PHI may be used for the purpose of obtaining patient support services, including but not limited to copay cards, free drug, medication therapy management, reimbursement assistance, or disease based support programs as administered by those identified in Section III. Such financial assistance may include covering co-payments or full or partial costs of my treatment.

V. Expiration Date

This Authorization will remain effective, unless revoked by me in writing, until the end of my treatment relationship with Meijer Specialty Pharmacy.

VI. Notices

I understand that once PHI 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.







Patient Authorization and Notice of Release of Information (continued)

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 Meijer’s treatment of me.

I understand that this Authorization will remain in effect until it expires as described above or I provide a written notice of revocation by mail to Meijer Specialty Pharmacy, 2929 Walker Ave NW, Grand Rapids, MI 49544, or via fax to 1-855-963-4537. The revocation will be effective immediately upon Meijer’s receipt of my written notice, except that the revocation will not affect any disclosures by Meijer or others referenced in this Authorization in reliance on this Authorization before Meijer received my written notice of revocation.

VII. 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.

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|  Patient’s Name |  Signature of Patient or Representative |  Date |
|  Description of Representative Authority |  Address of Patient |  Patient’s Date of Birth |