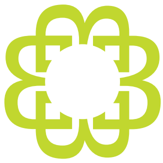
# Patient Authorization Form



## Please fax completed Patient Authorization form with Enrollment form to **1-855-578-1686**.

The Patient Authorization Form authorizes your healthcare provider to disclose your health and personal information to TrialCard, the administrator of the BOSULIF® (bosutinib) Trial Prescription Program, and its employees, representatives, and agents (collectively, "TrialCard"), in connection with the BOSULIF Trial Prescription Program in accordance with the Health Insurance Portability and Accountability Act of 1996 and related federal regulations and rules ("HIPAA").

## Authorization

I, .................................................................................................... hereby authorize ...................................................................
(First Name) (Middle Name) (Last Name) (Name of Physician [Healthcare Provider])

to disclose my individually identifiable health and medical information described below to TrialCard solely for the authorized purposes described in this authorization form.

## Description of Health and Medical Information That May Be Disclosed

My healthcare provider may disclose individually identifiable health and other information that supports my participation in the BOSULIF Trial Prescription Program. Information disclosed may include my name, address, date of birth, diagnosis/disease treatment, financial information, medical records, and the specialty of my healthcare provider.

## Authorized Purposes

The authorized purposes are: (1) to evaluate my eligibility for inclusion in the BOSULIF Trial Prescription Program and (2) if my participation in the program is approved, for the administration of the program to me.

## Expiration of Authorization

My authorization shall expire (1) when my participation in the BOSULIF Trial Prescription Program is not approved, or (2) at the conclusion of my participation in the BOSULIF Trial Prescription Program, or (3) if and when I revoke my authorization, whichever is earliest.

## Acknowledgments

1. I understand that once my healthcare provider gives TrialCard information about me based on this authorization, my medical and health information may be subject to redisclosure and no longer protected by federal privacy regulations. I further understand and agree that TrialCard may retain my medical and health information as disclosed under this authorization after this authorization expires for purposes related to the administration of the BOSULIF Trial Prescription Program. I also understand that in the event of an audit, and only for purposes of such an audit, some information may also be disclosed to Pfizer, the manufacturer of BOSULIF, even after this authorization has expired, so long as the audit is for a period of time when this authorization was in effect.
2. I understand that I may refuse to sign this authorization form and that, unless allowed by law, my refusal to sign will not affect my ability to obtain treatment from my healthcare provider; or to seek payment; or my eligibility for benefits. However, I understand that I may not be included in the BOSULIF Trial Prescription Program if I refuse to sign this authorization form.
3. I understand that I may revoke my authorization at any time by providing a written notice of same to my healthcare provider that refers to (or with a copy of) this authorization form. However, I understand that if I revoke this authorization, it will not affect prior disclosures made by my healthcare provider to TrialCard in reliance of this authorization.

Signature of patient or patient's personal representative .................................................................... Date ..............................

Patient's name ..........................................................................................................................................

Name of personal representative (If Applicable) ........................................................ Relationship to patient ...................................

**HEALTHCARE PROVIDERS MUST GIVE PATIENT AND/OR PATIENT'S REPRESENTATIVE A SIGNED COPY OF THIS FORM.**

☐ **Healthcare provider has verified Patient Representative's authority to act on Patient's behalf**

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