Patient Authorization

RELiZORB®
(iMMOBILIZED LIPASE) CARTRIDGE

Please complete this form and email to info@relizorbsupport.com or fax to 1-844-233-3146.
Please note—ALL INFORMATION IS REQUIRED to expedite processing of referral.

In order to receive RELiZORB Support Services, you must complete this RELiZORB Patient Authorization form. Please note that you do not need to complete this authorization in order to start on RELiZORB. Call 1-844-632-9271 to reach RELiZORB Support Services or visit www.relizorb.com for more information.

Patient Authorization Statement

Authorization to Share Protected Health Information (PHI) in Accordance with HIPAA and Other Applicable Laws

Some information that RELiZORB Support Services needs to obtain from my healthcare provider(s) and health plan(s) about me, such as my name and address, my health insurance benefits, prescription drug coverage and drug and medical information (including, without limitation, medical conditions, treatment, and drug history) may be "protected health information" under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The collection, use, and disclosure of such protected health information is protected under federal and state privacy laws, including HIPAA. In order for RELiZORB Support Services to provide me with the services described below ("RELiZORB Support Services"), the staff may need to ask for and receive from my healthcare provider(s) and health plan(s) the protected health information about me as described above.

By signing this Patient Authorization Statement, I hereby authorize my healthcare providers (such as my doctor, pharmacies, and pharmacists) and health plan and/or health insurer(s) to disclose protected health information about me to Alcresta Therapeutics, Inc., the manufacturer of RELiZORB, its employees, and the companies working with it (collectively, "Alcresta") to provide RELiZORB Support Services so that it may use and/or disclose this information for the following purposes:

1. Verify insurance coverage for RELiZORB.

2. Help to arrange financial assistance to help pay for my RELiZORB treatment by contacting my insurer, other potential funding services, social workers, patient advocacy organizations, or patient assistance programs on my behalf in order to determine if I am eligible for other financial assistance and to obtain such financial assistance.

3. Coordinate delivery of and access to RELiZORB.

4. Provide educational and support services and materials related to RELiZORB treatment.

5. Collect information related to RELiZORB treatment to assist in the coordination of care, efforts to obtain reimbursement for RELiZORB, and to demonstrate the safety and efficacy of RELiZORB.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by RELiZORB Support Services and no longer be protected by federal privacy regulations, including HIPAA.

I understand that my healthcare professionals, health plans, and health insurers may not condition treatment, payment, enrollment in a health plan, or eligibility of benefits on whether or not I sign this authorization. I acknowledge, however, that Alcresta may not be able to provide me with full RELiZORB Support Services described above unless Alcresta is able to receive from my healthcare providers, health plans, and health insurers the protected health information described in this authorization.

I understand that I have a right to receive a copy of this signed authorization upon request. I understand that I may cancel this authorization at any time by contacting Alcresta at 1-844-632-9271 or in writing at relizorb@alcresta.com. My cancellation will not apply to protected health information already disclosed by my healthcare providers and health plans and insurers to RELiZORB Support Services on the basis of this authorization before they learn that I have canceled it. This authorization will expire when I contact Alcresta to cancel it.

I also authorize Alcresta to contact me by phone, email, and/or mail in order to provide me with information related to RELiZORB or to ask me about my experiences with, or thoughts about, products, services, and programs that Alcresta offers or sponsors. My signature on this Patient Authorization Statement verifies that I understand and agree that any information I provide may be used by Alcresta to help develop new products, services, and programs.

Patient Name (please print):

Patient Signature ❯ **Date:**

Permission to contact patient/patient representative? Yes ☐ No ☐ Best time to contact:

If signed by a representative, please describe the representative's authority to act on behalf of the patient (Note: office personnel cannot sign on behalf of the patient):

I am acting for another person, and I hereby affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient or otherwise have a valid power of attorney to act on behalf of the patient.

Representative Name (please print):

Representative Signature ❯ **Date:**

ALCRESTA® THERAPEUTICS