

Confirmation of Patient Authorization for Release of Information by Renal Health Professional

TO: RenassistSM Helpline

From:

RE: Patient Authorization

I certify and warrant that all patient information supplied to Genzyme Corporation's RenassistSM Helpline and/or Genzyme Corporation affiliates has been obtained pursuant to an appropriate patient authorization allowing for the release, transfer, and use of such information by Genzyme Corporation in accordance with State and Federal law for verification and/or preauthorization of patient's benefits.

I also warrant and represent that I have the full authority to make the certifications and warrants stated above.

Date

Print Name

Dialysis Center / MD Office

Title

Address

Signature

City, State, Zip

Email Address

Telephone Number

Facility Tax Identification Number

National Provider Identifier for Unit/Office



1-800-847-0069 (Helpline)
1-877-363-6732 (Fax)

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