

## Authorization for Release of Health Information

Patient Name: \_\_\_\_\_

I agree to allow \_\_\_\_\_ (dialysis center), \_\_\_\_\_ (MD office), my health insurer, my pharmacy and/or pharmacy distributor and Genzyme Corporation's Renassist Program (collectively, the "Parties") to:

- Disclose; and/or
- Receive; and
- Use

my health information regarding my diagnosis of renal disease ("Disease"), treatment, payment or insurance coverage for selected renal products manufactured and/or distributed by Genzyme Corporation. Such health information includes, but is not limited to:

- Medical records and reports; and/or
- Histories and findings; and/or
- Prognosis and plan of care

for the purposes described below:

Coordination of Care: for consultation among the Parties for the coordination of my medical care related to the Disease.

Disease Management/Patient Education: provide disease education or disease management to me (or my legal representative), my physician, and my health insurer.

Reviewing my Insurance Benefits/Plan: to review and verify the benefits provided by my insurance plan, to assist me in understanding these benefits, to coordinate my benefits, perform insurance verification, prior authorization, reimbursement and to identify other sources of payment if necessary.

Other Use of Information: to de-identify the Information about me and to use this de-identified information in performing clinical research, patient and community education, clinical protocol development, marketing studies or for other commercial purposes.

Renassist will not release my Information to any person or entity other than those listed above without first getting my (or my legal representative's) separate written authorization. Once my Information has been disclosed to a third party, federal privacy laws may no longer protect it from further disclosure. However, Renassist agrees to protect my Information by using and disclosing it only as allowed by me in this Authorization or as otherwise allowed by law.

I do not have to sign this Authorization. A decision by me not to sign this Authorization will not affect my ability to obtain medical care or my eligibility or enrollment for insurance benefits. However, if I do not sign this Authorization, Renassist will not be able to provide the services described above.

This authorization supersedes any previous authorization signed for this purpose.

(Continued on back)

This Authorization shall remain in effect until revoked (taken back) by me or until I am no longer a patient of \_\_\_\_\_ (dialysis center). I may change my mind and revoke (take back) this

Authorization at any time by sending a letter that includes my name, address, and the date of the letter to: Renassist, c/o Genzyme Corporation, 500 Kendall Street, Cambridge, MA 02142, ATTN: Renassist<sup>sm</sup>. However, revoking (taking back) the authorization will not affect any use or disclosure of the Information made before my request is received and processed.

I will be given a copy of this Authorization after I have signed it, and a copy may be kept with my medical records kept at \_\_\_\_\_ (dialysis center), and/or by Renassist or my health insurer.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

*Complete the following only if the person signing this Authorization is not the patient:*

Person Authorizing Release: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Custodial Parent

(Check one) \_\_\_\_\_ Legal Guardian or Representative

Witness to Signature: \_\_\_\_\_

Print Name of Witness: \_\_\_\_\_

In order to begin this process, please provide the following information:

I am currently taking a Phosphate Binder: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, I am taking the following Phosphate Binder (please circle):

Renagel®  
Renvela®  
Phoslo®  
Tums®  
Other Calcium Binder  
Aluminum Binder  
Other: Please Specify \_\_\_\_\_

I am currently taking Vitamin D therapy: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, I am taking the following Vitamin D therapy (please circle):

Hectorol®  
Zemplar®  
Calcitriol  
Other: Please Specify \_\_\_\_\_

I am an honorably discharged veteran of the US Military. Yes \_\_\_\_\_ No \_\_\_\_\_

I am a dependent or survivor of a veteran of the US Military. Yes \_\_\_\_\_ No \_\_\_\_\_