Saint Michael's Medical Center

PATIENT ASSISTANCE PROGRAM

Please read and sign this authorization for the Patient Assistance Program. This authorization will be used by Cardinal Health acting as agent of SMMC to contact the drug manufacturing companies regarding your medications. All information obtained will be kept in strict confidence.

Dear Patient:
Saint Michael's Medical Center, Inc. in its mission to provide to persons of limited resources often participates in programs that offer drugs at no cost or reduced prices for persons being treated with certain medications. The nature of your illness and treatment being described for you may qualify you for participation in one of these programs, such as that Patient Assistance Programs. The Hospital Assistance Program may require that you disclose your financial status, illness, and/or treatment to the drug manufacturing company sponsoring the program. Your signature is required on certain forms to allow this disclosure. Once we disclose health information, privacy laws may no longer protect it.

By signing this authorization, you authorize the reimbursement specialist(s) to sign any and all forms and applications on your behalf and to access release any demographic, diagnostic, therapeutic, and/or financial information required to apply for drug manufacturing company patient assistance programs. You may revoke this authorization at any time by contacting SMMC, Inc. reimbursement office at 973-877-2889. Furthermore, by signing this letter, you attest that this information you have provides is true and accurate. You also release any claim to the medications you may receive as a result of your participation in the Patient Assistance Program. This information will remain confidential wihtin SMMC, Inc. and only be released to the drug manufacturing company sponsoring the program in compliance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and state law.

In accordance with SMMC, Inc. policy, failure to complete an application for all other sources for which you may be eligible will result in pharmacy benefits being denied or cancelled. Signing this form does not release you from any financial responsibility to SMMC., Inc. including but not limited to pharmacy dispensing fees.

I, _____ hereby give permission for the reimbursement specialist to sign on my behalf when seeking aid from drug manufacturing company Patient Assistance Programs. I understand that this authorization is effective until I express I am no longer participating in the Patient Assistance Program at SMMC, Inc.

Please Print:

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code** _____

Home Phone: _____ **Alternate Number:** _____

X _____ _____
Signature of Patient or Guardian **Date**