

# PATIENT PRIVACY AUTHORIZATION FORM

## FOR HUMATROPE® (somatotropin [rDNA origin] for injection)

You (patient, parent, or guardian) have expressed an interest in Humatrope® (somatotropin [rDNA origin] for injection) ("Humatrope") therapy for the following individual (who will be referred to in this Authorization as "you," "your" or "my"):

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

Address: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Eli Lilly and Company, together with its agents ("Lilly"), can provide free services to you and on your behalf during the search for reimbursement for Humatrope therapy, and during your therapy with Humatrope ("Services"). These Services may include:

- Helping your health care providers complete and process documents necessary to qualify you for Humatrope therapy; and
- Providing personal training on use of the Humatrope device.

In order to provide these Services, Lilly will need to use your health information (called "Protected Health Information" or "PHI") and to share your PHI with others. This authorization ("Authorization") will allow your health care providers, health plans, and health insurers ("Providers") that maintain PHI about you to disclose your PHI to Lilly so that Lilly may provide the Services. This Authorization also allows the Providers to disclose your PHI to a successor-in-interest to Lilly or any of Lilly's agents that are involved in providing the Services. This Authorization will allow Lilly and its agents to use your PHI, and to share it with others, as necessary to provide Services. Lilly will only use and share your PHI as described in this Authorization, or as otherwise permitted by law.

By signing this Authorization, you give permission for the Providers to disclose any of your PHI in the Providers' possession – whether in written, electronic, or oral form – to Lilly, including, but not limited to, all medical and surgical information, information about communicable diseases, drug and alcohol abuse treatment records, mental health records, billing and payment information, information about your insurance coverage, and identifying information about you, including name, address, date of birth, and Social Security Number. The PHI Lilly needs to use and share may include PHI that Lilly already has or PHI that Lilly receives in the future.

By signing this Authorization, you understand:

- (a) This Authorization will remain in effect for 36 months (unless otherwise limited by State law), or until you revoke it in writing as described herein. You may revoke it before its expiration date by providing written notice to your Providers and via mail to Eli Lilly & Co., c/o Humatrope Hotline, Lilly Corporate Center, Drop Code 5114, Indianapolis, IN 46285 or via fax to 317-276-8913. You should be aware that your revocation will not have any effect on actions the Providers or Lilly took in reliance on this Authorization before they received the revocation, or on any use or disclosure of your PHI that the Provider or Lilly made before it received the revocation.
- (b) This authorization is voluntary. If you choose not to sign this Authorization, your ability to obtain treatment from the Provider, and your eligibility for benefits under your health plan, will not be affected. However, if you choose not to sign this Authorization, Lilly may not be able to provide the Services described in this Authorization to you and on your behalf. For example, if you choose not to sign this Authorization, Lilly will not be able to provide one-on-one education to you about Humatrope or its administration. Furthermore, Lilly will not be able to help your health care provider complete and process documents necessary to qualify you for Humatrope therapy and reimbursement, and this qualification may be delayed or may not occur at all. This may result in your need to pay for certain products with your own funds.
- (c) Once your PHI is shared, reasonable efforts will be made to protect it, but some recipients of your PHI may not be subject to state and federal privacy laws. In those cases, your PHI may no longer be protected by federal or state privacy laws and may be redisclosed without being subject to those laws.

### Authorization and Signature:

I have read and understand the terms of this Authorization. I have had a chance to ask the Providers questions about the use and disclosure of my PHI. By signing below, I authorize the use and/or disclosure of my PHI in the ways described in this Authorization. I also agree to notify Lilly and my Providers about any changes to my information, including my address, telephone number, and insurance coverage.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name: \_\_\_\_\_

If you are signing this Authorization as a personal representative of the person to receive Humatrope, please state your authority for doing so (e.g., "mother" or "father" or "legal guardian"): \_\_\_\_\_

*Please return a signed copy of this form to your endocrinologist's office.*