HIPAA Authorization Form for the Disclosure of Patient Protected Health Information

To the Patient: Please complete this Authorization, sign and date it, and return it to the specialty pharmacy or distributor who will be handing your order (the "Distributor"). You are entitled to a copy for your records. The Distributor will retain the original or a copy of the signed Authorization with the patient's records and provide a copy to the patient.

Patient Information:

First Name: ________________________ *Last Name:* ____________________________ *DOB:* ____ /____ /________

I request and authorize the Distributor to use and share my Protected Health Information (my "Information") with Renovia Inc., its affiliates, contractors, agents and service providers who work on behalf of Renovia Inc. (collectively, "Renovia"). My Information may include my name and birth date, my address and telephone number, my email address, my Social Security number, financial information about me relevant to my order, information about my health benefits or health insurance coverage, information on my medical condition, information identifying my current health providers, medical order-related health records, information about my health care plan benefits, demographic, contact, and any other information bearing on my health. My Information may be used to provide me with the education, information, support, and other services provided by Renovia such as registering my product and periodic outreach calls and surveys. In addition, my Information may be used to verify treatment and payment decisions with my health care providers; investigate and assist with coordination of coverage for Renovia products; coordinate medical order fulfillment and financial assistance; perform internal analysis at Renovia to better meet patient needs; determine my eligibility for support services; to evaluate patient satisfaction; for marketing purposes; and for use in research and related publications. I understand that once the Distributor discloses my Information based on this Authorization, federal privacy laws, such as HIPAA, would not prevent Renovia from further disclosing my Information to other entities.

I know that I can revoke this Authorization at any time by writing to Renovia at: 263 Summer Street, Boston, MA 02210. If I revoke this Authorization, then Renovia will immediately contact the Distributor and then Distributor will stop providing my Information to Renovia and its representatives. However, I understand that any such revocation will not apply to any of my Information already used or disclosed based on this Authorization prior to Distributor's receipt of the revocation.

I understand that I can refuse to sign this Authorization and that this will not affect my treatment or payment for treatment, enrollment, insurance coverage, or eligibility for benefits. This Authorization will expire one (1) year after the date it is signed below, unless a shorter time period is required by state law.

Patient or Legally Authorized Representative of Patient (with Authority to sign on behalf of Patient *[if applicable]*)

Which best describes you?

☐ I am a patient

☐ I am a legally authorized representative *(if checked, please confirm your relationship with the patient)* __________________

Name *(please print)*: ____

Signature: ____

Date: ________________________________

Rev: May 2018

DME002.02