

GSK REIMBURSEMENT RESOURCE CENTER

Patient Authorization to Release and Disclose Medical Information

IMPORTANT: The patient, or the patient’s authorized representative, MUST sign this form in order to receive assistance from the GSK Reimbursement Resource Center (the “RRC”). Before signing, the patient, or the patient’s authorized representative, if any, must review, understand and agree to the disclosure and release. If an authorized representative signs for the patient, such authorized representative must indicate his/her specific relationship to the patient.

By my signature I authorize GlaxoSmithKline, as well as The Lash Group, Inc., and any other companies that GlaxoSmithKline uses to administer the RRC to do the following:

- 1) Request and receive from my doctor, healthcare provider, health insurer or pharmacist information necessary to investigate and resolve my coverage, coding or reimbursement inquiry.
- 2) Use and disclose to each other any information that I provide to the RRC for the purpose of investigating and resolving my coverage, coding or reimbursement inquiry or to administer the RRC.
- 3) Disclose to my treating physician, health care professional or pharmacist information provided to the RRC when necessary to resolve my coverage, coding or reimbursement inquiry. By signing below, I also authorize my insurer, doctor, healthcare provider, or pharmacist to release information about my prescribed medications and medical condition requested by GlaxoSmithKline and Lash Group.
- 4) Contact my insurer, other potential funding sources, social workers or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider, or pharmacist.
- 5) Disclose any information obtained from the sources listed above to third parties if required by law.

I understand that my healthcare providers will not condition my medical treatment on my agreement to sign this Authorization to Release and Disclose Medical Information.

I understand that once information about me is provided to the RRC based on this authorization, federal privacy laws may not prevent the RRC from further disclosing my information. However, I understand that the RRC has agreed that it will only use or disclose information it receives for the purposes described in this authorization or as required by law.

I understand that this Authorization to Release and Disclose Medical Information will remain in effect for 180 days or until my coverage, coding, or reimbursement inquiry has been resolved, whichever is longer.

I also understand that I have the right to revoke this authorization at any time by calling 1-800-745-2967, and mailing a signed written statement of my revocation to the RRC at the address below, but that such a revocation would end my eligibility to participate in the RRC. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on the authorization. This means that, after you revoke the authorization, your information may be disclosed among GSK and the company or companies that help GSK administer the RRC in order to maintain records of your participation, but it will not be otherwise disclosed or used.

Patient name (print)

Patient signature

Date

Relationship if other than patient: _____

**GSK Reimbursement Resource Center
P.O. Box 221425
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866-216-5292 fax
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