AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

***Patient instructions**: Please read the authorization and fill in the information below, including your signature and today's date. You should keep a copy given to you by the office.*

I authorize my healthcare providers and staff, health plan, and pharmacies (collectively, my "Healthcare Providers") to disclose individually identifiable information about me, my health or condition(s), treatment and care that I have received, my insurance coverage, my payment information, and my medication history and prescriptions (collectively, "Protected Health Information") to AbbVie Inc. and/or its designated affiliates, agents, representatives, and service providers (collectively, "AbbVie") in order for AbbVie to (i) enroll me in, provide, operate and administer the ("Program"); (ii) provide me with information concerning the Program; and (iii) develop, evaluate, and improve products, services, materials, and programs related to my condition or treatment. I understand that Protected Health Information disclosed to AbbVie under this Authorization will no longer be protected by HIPAA and may be subject to redisclosure by AbbVie. I also understand that my Healthcare Providers may receive benefits, which may include compensation, for my participation in the Program and the disclosure of my Protected Health Information. I understand that my Healthcare Provider may use my Protected Health Information to identify and provide information about products and services that may be of interest to me based on my participation in the Program. I understand that I am not required to sign this Authorization and that my Healthcare Providers will not otherwise condition my treatment, payment, health insurance enrollment, or eligibility for healthcare benefits to which I am otherwise entitled on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the Program. I understand that this Authorization will expire once I am no longer participating in the Program, unless I cancel it sooner. I understand that I may cancel this Authorization at any time by making a data subject rights request at https://abbviemetadata.my.site.com/AbbvieDSRM or by writing to privacydsr@abbvie.com. However, I understand that if I cancel this Authorization, it will end my enrollment in the Program. I understand that cancelling this Authorization will not affect any use or disclosure of my Protected Health Information that has already taken place in reliance on this Authorization.

By signing this Authorization Form, I certify that I have read, understood, and agree to the release of my Protected Health Information pursuant to this Authorization.

Note: You have a right to receive a copy of this Authorization. You may print a copy of or save this Authorization and retain a copy for your records

I verify the information provided is true and correct. If I am the caregiver/representative of the patient, I confirm I am authorized to sign on behalf of the patient.

(Fields marked with* are required)

*First name: Middle initial:

*Last name: *Gender:

*Date of birth: (MM/DD/YYYY) *Phone number:

*Address line 1:

Address line 2:

*City:

*State: *ZIP code:

*Signature: *Date:

Representative name (print, if applicable):

Email:

FOR OFFICE ONLY: FAX the signed authorization to 1.678.727.0690. Provide patient with a copy of this signed document.

COMPLETE
Patient Support Programs

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