CRANBURY Connects

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FAX (732) 647.2128
CranburyConnects@trispharma.com

Patient Authorization

Patient Name: _____ **Date of Birth:** _____

I authorize my health plan, physician, healthcare professional, hospital, clinic, pharmacy provider, or other healthcare provider (collectively, "Providers") to disclose my personal health information, including personal information relating to my medical condition, treatment, care management, health insurance, and contact information ("Information"), to Cranbury Pharmaceuticals, LLC, its affiliates, and their representatives, agents, and contractors (collectively, the "Company"). I authorize Company to provide this Information, and any specific information related to my prescription that I provide to the Company directly, to a specialty pharmacy to fulfill the prescription. Further, my Providers and the Company may use and disclose this Information for support services, such as verification of insurance benefits and drug coverage, prior authorization support, financial assistance with copays, patient assistance programs, alternate funding sources, other related programs, and communication with me or my prescribing physician by mail, email, or telephone about my medical condition, treatment, care management, product information, and health insurance. This Information may also be used for internal purposes by the Company, including data analysis, or to improve, develop, and evaluate products, services, and programs related to my condition. I also authorize the Company to use my Information to provide me with educational and/or promotional information about Deflazacort and related Company products and services, adherence reminders and support, and disease education, and to contact me to conduct market research. I understand that my Providers may receive payment for activities described in this authorization. I understand that once disclosed to the Company, my Information disclosed under this Authorization may no longer be protected by applicable privacy laws, including HIPAA. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by sending written notice of revocation to Cranbury Pharmaceuticals, LLC, 2031 US Highway 130, Monmouth Junction, NJ 08852. I understand that such revocation will not apply to any Information already used or disclosed through this Authorization. I understand that revoking my Authorization will end my participation in Cranbury Connects™. This Authorization will remain in effect for five (5) years from the date this Authorization is signed by me unless a shorter period is provided for by law. I understand that I may refuse to sign this Authorization and that refusing to sign this Authorization will not change my Provider's treatment or my insurance benefits. I also understand that if I do not sign this Authorization, I will not be able to receive Cranbury Connects™ services.

Patient/Legal Guardian Name: _____

Signature: _____

Relationship: _____ **Date:** _____