

# PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION (PAN)



Phone: (888) 587-9438 Fax: (866) 827-8188 [BonivaReimbursement.com](http://BonivaReimbursement.com)

## Boniva Reimbursement is a free program for you from Genentech.

We work to help you pay for your Boniva® (ibandronate sodium). We can help in many different ways. We assist people who have a health care plan as well as those who don't.

If you don't have a health care plan, or your plan won't pay for your Boniva, we might be able to help. If you meet certain financial and medical standards, we can supply free medicine. This is done through the Genentech® Access to Care Foundation (GATCF).

For us to help, we need to look at, use and disclose your personal health information (PHI). Your doctor and health care plan may disclose your PHI to us only with your written consent. Once you sign this form and it is sent back to us, we can start to provide these services. We can provide you with a copy of this release. You need to ask us for this first before we can send the copy back to you.

**You do not have to agree to this authorization.** But we cannot provide our services without your consent. This means you might need to pay for certain medicines on your own.

PLEASE READ THROUGH THIS FORM CAREFULLY. IF YOU HAVE ANY QUESTIONS, TALK TO YOUR DOCTOR'S OFFICE OR CALL US AT THE PHONE NUMBER LISTED AT THE TOP OF THIS PAGE.

## 1. Information to Be Disclosed or Used

This signed form lets my doctors and health care plans send my PHI to Boniva Reimbursement and/or GATCF. This includes:

- All my health records relating to my treatment
- Information about my health care plan benefits
- The dollar balance left on the total of the lifetime payments covered by my health care plan policy (if this applies to my plan)
- Any information having a bearing on my health or my adherence to my treatment

All of the above is considered part of my PHI. I know this could include information about:

- Sexually transmitted diseases
- Mental health conditions
- Genetic test results

We are not looking for this information. It might be part of the medical record sent to us.

## 2. Who May Disclose My PHI

My PHI may be released by my doctor. It may also be released by my health care plan or others who might hold my PHI.

### 3. Who May See My Personal Health Information (PHI)

My PHI may be seen by Boniva Reimbursement and/or GATCF. These are programs sponsored by Genentech. Its address is 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. It may also be seen by anyone helping Boniva Reimbursement perform services including Genentech employees and any of Genentech's partners.

### 4. How My PHI May Be Used

My PHI may be used only in these ways:

- Helping with my health care plan coverage for Boniva® (ibandronate sodium)
- Applying to GATCF
- Tracking my use of Boniva
- Measuring the help offered by Boniva Reimbursement

### 5. Expiration Date

This release is in effect for 1 year once I have signed it. I may also withdraw it in writing at any time.

### 6. Notices

Once I sign this form, I know my PHI might not be covered by any federal law about the use of my PHI or how it is disclosed. There is no guarantee my PHI might not be released to a third party. This third party might not need to follow the conditions of this release.

I know I can refuse to sign this form. I may withdraw it at any time and for any reason. This won't affect the start or continuing of my treatment. It will have no effect on the quality of my treatment.

I know this release stays in effect for 1 year or until I withdraw it in writing. To withdraw it, I must send a written notice to Genentech. It can be sent by fax or by mail to the address at the bottom of this page. This withdrawal goes into effect once it is received by Genentech. It will have no impact on my treatment by my doctor.

If I don't sign this form or withdraw it, I may be responsible for the costs of my treatment.

### 7. Distribution Acceptance

If I receive free product from GATCF, I will use Boniva as my doctor has prescribed it to me. I will not sell or distribute Boniva. I understand it is unlawful to do this. I am responsible for ensuring Boniva is sent to a secure address when it is shipped to me. I know it is my duty to control Boniva while it stays in my possession.

#### **SECTION 8 ON THE NEXT PAGE IS REQUIRED.**

This written notice must be signed, dated and mailed or faxed to:

**Boniva Reimbursement**  
PO Box 29064  
Phoenix, AZ 85038

**Fax: (866) 827-8188**

**8. Signature and Date (REQUIRED)**

You must sign  
and date here

I have read and understand the terms of this release form. I have had the chance to ask questions about the use of my personal health information (PHI) and who may see it. By signing this form below, I know I am releasing my PHI as discussed in this form. **(Please fill in all information below. Be sure to sign and date this form. If you don't, it could hold up the process for helping you.)**

\_\_\_\_\_  
Signature of Patient or Guardian\*

\_\_\_\_\_  
Description of Authority

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Patient/Guardian Address

\*If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally).

**9. Financial Information**

Fill out this section only if you want to apply for help from GATCF.

**Household Adjusted Gross Income:**  \$0-\$25,000/yr       \$25,001-\$50,000/yr  
 Other: \_\_\_\_\_

I know that to qualify for free medicine, my household adjusted gross income may not be more than \$50,000 per year. I certify the above statement of my income for last year is true. I certify I have no health plan coverage for Boniva® (ibandronate sodium). This includes Medicare, Medicaid or other public programs. I do not have the financial resources to pay for Boniva. I agree to give GATCF proof of my income. This may be a copy of my IRS 1040 form from last year. It may be other proof of my income as well. I will send this to GATCF within 45 days after this form is submitted. I know if I fail to supply this, GATCF won't be able to keep helping me.

Sign and date  
here (if needed)

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date