

# Health Insurance Portability and Accountability Act "HIPAA" Authorization for Release of Medical Information

I hereby authorize BioPlus Specialty Pharmacy Services, Inc., and their network of pharmacies, MedScripts Medical Pharmacy, River Medical Pharmacy, and Route 300 Pharmacy (the "BioPlus Pharmacies"), and their agents and employees, to use and disclose prescription, insurance, diagnosis and other information pertaining to the health and condition (the "Information") of the identified patient ("Patient"). I authorize the Information to be disclosed among the BioPlus Pharmacies and to drug manufacturers, patient assistance programs, and research organization ("Designees") and their respective agents.

The authorized purposes for such use or disclosure are to provide Patient with and coordinate Patient's healthcare; provide Patient with reimbursement support and healthcare product and service offerings; or for BioPlus Pharmacies' or Designees' analysis of business processes, disease therapy treatment, or drug therapy treatment. I acknowledge that the BioPlus Pharmacies may receive payment from third parties for such use or disclosure of the Information.

This authorization expires five (5) years from the date of my signature or when my treatment or course of medication facilitated through a BioPlus Pharmacy is complete, whichever occurs first.

I understand that the information disclosed under this authorization may be re-disclosed by the recipients and may no longer be subject to the same protections the information is given by the BioPlus Pharmacies.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon this authorization, by sending written notification to:

**Privacy Officer,  
BioPlus Specialty Pharmacy  
376 Northlake Blvd.  
Altamonte Springs, FL 32701**

I understand that I may also receive a copy of this authorization by sending a written notification to the same address.

I understand that I have the right to refuse to sign this authorization. I understand that BioPlus Pharmacies may not condition the provision of treatment or payment based on my refusal to sign this authorization.

<b>Patient Name ("Patient"):</b>	
<b>Patient Signature:</b>	
<b>Former/Alias/Maiden Name (if applicable):</b>	
<b>Date of Birth:</b>	
<b>Date:</b>	
<b>Name of Personal Representative (If Applicable):</b>	
<b>Signature of Personal Representative (If Applicable):</b>	
<b>Description of Personal Representative's Authority:</b>	