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

I hereby authorize BioPlus Specialty Pharmacy Services, LLC and their network of pharmacies, MedScripts Medical Pharmacy, River Medical Pharmacy, Route 300 Pharmacy, and Santa Barbara Specialty 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 organizations ("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 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 by sending written notification to
Privacy Officer, BioPlus Specialty Pharmacy, 376 Northlake Blvd., Altamonte Springs, FL 32701,
except to the extent that action has already been taken in reliance upon this authorization.

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.

Patient Name ("Patient"): _____

Patient Signature: _____

Former/Alias/Maiden Name (If applicable): _____

Date of Birth: _____

Date: _____

Name of Personal Representative (If applicable): _____

Signature of Personal Representative (If applicable):_____

Description of Personal Representative's Authority: