Purified Cortrophin® Gel repository corticotropin injection USP 80 U/mL

Patient Authorization

Once completed, please fax form to 1-218-634-3533

Patient Full Name

Date of Birth (mm/dd/yyyy)

Mobile Phone #

ZIP Code

Patient Authorization for Use and Disclosure of Protected Health Information

I authorize my healthcare providers (including pharmacy providers) and health plans to release or disclose my protected health information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ["HIPAA"] and its regulations), including my personal contact and other information on this form, all medical records, financial information, and other information (collectively, "Information") relevant to my enrollment, participation, or receipt of assistance under the *Cortrophin In Your Corner*™ program (the "Program"), to ANI Pharmaceuticals and its affiliates, and any third parties engaged to assist in administering the Program, in order to: (1) establish my benefit eligibility; (2) communicate with my healthcare providers and health plans about my eligibility for Program support, my benefit and coverage status, and/or my medical care; (3) provide support through the Program, including facilitating the provision of the Cortrophin Gel ("Product") to me, as well as any information or materials related to such support or Product, including marketing, promotional, or educational communications; (4) evaluate the effectiveness of Product support programs; (5) contact me regarding this enrollment form or my use or potential use of the Product and providing me with related patient support communications, including through messages left for me that disclose that I take or may take the Product; (6) facilitate or assist on copayment, coinsurance, and patient assistance program ("PAP") matters, as applicable; and (7) administer, evaluate, and improve the Program, including by analyzing the usage patterns and the effectiveness of ANI Pharmaceuticals products, services, and programs; helping to develop new products, services, and programs; and for other ANI Pharmaceuticals general business and administrative purposes.

I understand that certain entities may receive remuneration for the use or disclosure of my Information and providing support services as authorized above, and that, once my Information has been disclosed under this Authorization, my Information may not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. I also understand, however, that the Program plans to use and disclose my Information only for the purposes described above or as required by law.

I understand that I may refuse to sign this Authorization and that my refusal to sign this Authorization will not affect my right to treatment or payment of benefits for healthcare. I understand that if I refuse to sign, I will not be eligible to receive support through the Program. I may later withdraw this Authorization by sending written notice of my withdrawal from the Program to *Cortrophin In Your Corner*, PO Box 52182, Phoenix, AZ 85072-2182. Withdrawal of this Authorization will end further uses and disclosures of my Information by my healthcare providers and health plans under this Authorization, except to the extent those uses and disclosures have been made in reliance on this Authorization and as permitted by applicable law. I am entitled to receive a copy of this signed Authorization, which expires 10 years after the date it is signed by me unless otherwise specified by state or other applicable law or revoked by me earlier in writing.

PATIENT NAME OR LEGAL REPRESENTATIVE	**SIGNATURE**	**IF LEGAL REPRESENTATIVE, EXPLAIN AUTHORITY TO ACT ON BEHALF OF PATIENT AND RELATIONSHIP***	**DATE**

ani Pharmaceuticals, Inc.

*By signing on behalf of the patient as representative or guardian, I attest that I am legally able to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient may be requested such as power of attorney or legal court order.

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