

KALBITOR AccessSM patient authorization

In order to receive KALBITOR Access services, you must complete and fax this authorization to KALBITOR Access at 1-888-806-4829. Please note that you do not need to complete this authorization to start KALBITOR.

Authorization to Share Protected Health Information

Some Information collected by KALBITOR Access, such as my name and address, and personally identifiable insurance, prescription, and medical information, is “protected health information.” The collection, use and disclosure of such protected health information are protected under law. In order for the KALBITOR Access program to provide me with the services described in the KALBITOR Access overview for patients, the staff may need to review, use, and share my protected health information with certain authorized individuals.

By signing the KALBITOR Access Patient Authorization, I agree to the collection, use, and disclosure of my protected health information to coordinate the delivery of my care. I am giving the KALBITOR Access program the right to request, receive, collect, use, and disclose information from my doctor, healthcare provider, health plan, health insurer, pharmacist, or others necessary to assist with (1) establishing insurance coverage for KALBITOR; (2) helping to arrange financial assistance to help pay for my KALBITOR treatment by contacting my insurer, other potential funding sources, social workers, patient advocacy organizations, or patient assistance programs on my behalf in order to determine if I am eligible for other health insurance coverage funds; (3) coordinating delivery and administration of KALBITOR to my designated treatment site(s); (4) providing educational and support services related to KALBITOR treatment; (5) providing a central collection point for information related to KALBITOR treatment to assist in the coordination of care; and/or (6) disclosing any information obtained from the sources listed above to third parties if required by law. I understand that information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.

I understand that my healthcare professionals, health plans, and health insurers may not condition the provision to me of treatment, payment, enrollment in a health plan, or eligibility of benefits on whether or not I sign this authorization. I acknowledge, however, that Dyax Corp., the manufacturer providing KALBITOR, will not be able to provide me with the KALBITOR Access services described above unless the KALBITOR Access program staff is able to receive from me, my healthcare professionals, health plans, and health insurers the protected health information described in this authorization.

I understand that I may inspect or copy the protected health information to be used or disclosed. I understand that I will receive a copy of this signed authorization.

I may cancel this Authorization at any time by faxing a letter to the KALBITOR Access program at 888-806-4829. My cancellation will be effective as of the date of receipt of the letter canceling the Authorization. My cancellation will not be effective to the extent that the authorized individuals listed above have already relied on my authorization, and/or information has been disclosed to a third party. Unless cancelled sooner, this Authorization will expire 1 year from the day it is signed.

I have read and understand the Authorization to Share Protected Health Information and hereby authorize Dyax to share my health information for the purpose of coordinating my KALBITOR treatment.

X Patient/Guardian signature: _____ Date: _____

X Print Patient Name: _____

X Contact Phone Number: (____) ____-_____

X Patient Date of Birth: ____\ ____

**Fax the completed form to KALBITOR Access at 1-888-806-4829.
Call KALBITOR Access at the number below with questions.**