Patient Authorization Form

RELiZORB™
(iMMOBILIZED LIPASE) CARTRIDGE

Please fax this completed form to:
RELiZORB Support Services at 1-844-890-1900

Call 1-844-RELiZORB (1-844-735-4967) to reach RELiZORB Support Services or visit www.relizorb.com for more information

In order to receive RELiZORB Support Services, you must complete this RELiZORB Patient Authorization form. Please note that you do not need to complete this authorization in order to start on RELiZORB.

Authorization to Share Protected Health Information (PHI) in Accordance with HIPAA and Other Applicable Laws

Some information that RELiZORB Support Services needs to obtain from my health care provider(s) and health plan(s) about me, such as my name and address, my health insurance benefits, prescription drug coverage and drug and medical information, including medical conditions, treatment and drug history, is "protected health information" under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The collection, use and disclosure of such protected health information is protected under federal and state privacy laws, including HIPAA. In order for RELiZORB Support Services to provide me with the services described below ("RELiZORB Support Services"), the staff may need to ask for and receive from my health care provider(s) and health plan(s), the protected health information about me as described above.

I hereby authorize my health care providers (such as my doctor and pharmacies and pharmacists) and health plan and/or health insurer to disclose protected health information about me to Alcresta Therapeutics Inc., the manufacturer of RELiZORB, its employees, and the companies working with it ("Alcresta") to provide RELiZORB Support Services so that it may use this information as necessary to:

1	Establish insurance coverage for RELiZORB.
2	Help to arrange financial assistance to help pay for my RELiZORB treatment by contacting my insurer, other potential funding services, social workers, patient advocacy organizations, or patient assistance programs on my behalf in order to determine if I am eligible for other financial assistance.
3	Coordinate delivery of and access to RELiZORB.
4	Provide educational and support services and materials related to RELiZORB treatment.
5	Collect information related to RELiZORB treatment to assist in the coordination of care.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by RELiZORB Support Services and no longer be protected by federal privacy regulations, including HIPAA.

I understand that my healthcare professionals, health plans, and health insurers may not condition treatment, payment, enrollment in a health plan, or eligibility of benefits on whether or not I sign this authorization. I acknowledge however, that Alcresta may not be able to provide me with full RELiZORB Support Services described above unless Alcresta is able to receive from my healthcare providers, health plans, and health insurers the protected health information described in this authorization. I understand that I have a right to receive a copy of this signed authorization upon request.

I understand that I may cancel this authorization at any time by contacting Alcresta at 1-844-RELiZORB (1-844-735-4967) or in writing at relizorb@alcresta.com. My cancellation will not apply to protected health information already disclosed by my health care providers and health plans and insurers to RELiZORB Support Services on the basis of this authorization before they learn that I have cancelled it. This authorization will expire when I contact Alcresta to cancel it.

Optional - Authorization for Use of My PHI to Contact Me for Marketing, Research & Development Purposes

_____ By initialing here, I also authorize Alcresta to contact me by phone, email, and/or mail in order to provide me with information related to RELiZORB or to ask me about my experiences with, or thoughts about, products, services, and programs that Alcresta offers or sponsors. By initialing here and signing below, I understand and agree that any information I provide may be used by Alcresta to help develop new products, services and programs. I understand that this section is optional and that I do not have to initial this section to receive the RELiZORB Support Services as described above.

I have read and understand this authorization.

Patient/Guardian Signature: Date:

Print Patient Name: Date:

Contact Phone Number:

Patient Email Address:

Patient Mailing Address:

ALCRESTA™
THERAPEUTICS