

Pfizer Inc. Patient Assistance Programs
Authorization for the Disclosure of Patient Information

To Patient:

The attached authorization is for you and your doctor. If you sign this agreement, you are allowing your doctor to give Pfizer information about you that will help you get your Pfizer medications. An example of the type of information we need from your doctor would be the prescription for the medicine you need. This agreement is between you and your doctor only. **Please sign and give your doctor the original signed authorization and keep a copy for your records. This form should not be returned with your application**

To Physician:

The attached authorization, when signed by your patient, documents the patient's permission for you to share certain medical and personal information with Pfizer in connection with Pfizer's patient assistance programs. **This authorization is strictly for your records and should not be returned with your patient's application.**

**AUTHORIZATION TO DISCLOSE INFORMATION ABOUT ME
FOR PFIZER INC. PATIENT ASSISTANCE PROGRAMS**

To the Patient: Pfizer Inc. offers patient assistance programs (the "Program") to help patients who qualify obtain certain Pfizer medicines at no cost. In order to determine your eligibility for the Program and to administer your participation in the Program if you are accepted, Pfizer, along with its affiliated companies and contractors who administer the Program, need to obtain certain information about you from your doctor. Pfizer agrees that it will only use this information to determine your eligibility for this Program, to administer the Program, and to account for your withdrawal if you decide to stop participating in this Program. **Please complete this Authorization, sign and date it, and return it to your doctor.**

To the Physician: **Please retain the original signed Authorization with the patient's records and provide a copy to the patient. You do not need to return this patient Authorization to Pfizer.**

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I request and authorize my doctor, _____ ("Doctor"), to give Pfizer Inc., including representatives and contractors who work on behalf of Pfizer in this Program, information about me and my medical condition, which is necessary to determine my eligibility for the Program and for my continuing participation in the Program if I am accepted. The type of information that may be given under this authorization includes:

- My name and birth date
- My address and telephone number
- My social security number
- Financial information about me
- Information about my health benefits or health insurance coverage
- Information on my medical condition, as necessary

I know that I can cancel this authorization at any time by writing to my Doctor at _____ . If I cancel this authorization, then my Doctor will stop providing Pfizer, and its representatives, with information about me. However, I cannot cancel actions that have already been taken by relying on my authorization.

I understand that once my Doctor gives Pfizer information about me based on this authorization, federal privacy laws may not prevent Pfizer from further disclosing my information. I also understand that signing this authorization does not guarantee that I will be accepted into a Pfizer patient assistance program.

This authorization will expire one (1) year after the date it is signed, below, or one (1) year after the last date I receive medicines under the Program, whichever is later.

Please return the signed form to your Doctor. You are entitled to a copy for your records.

Patient or Personal Representative of Patient

Signature

Date _____

Name (Please Print)

Authority to sign on behalf of Patient (if applicable)