WESTERN MARYLAND
HEALTH SYSTEM

Caring for What Matters Most

Patient Authorization Form: Pharmacy Assistance Program

Please read and sign this authorization for the Patient Assistance Program. The information on this authorization will be used by Cardinal Health, acting as agent of Western Maryland Health System, to contact the drug manufacturing companies regarding your medications. All information will be kept in strict confidence.

Dear Patient:

Western Maryland Health System, in its mission to provide healthcare to persons of limited resources, often participates in programs that offer drugs and other therapies (i.e. stents, etc.) at no cost or at reduced prices for persons being treated for certain illnesses. The nature of your illness and the treatment prescribed for you may quality you for participation in one of the programs, such as the Pharmacy/Patient Assistance Program (PAP). The PAP may require that you disclose your financial status, illness and/or treatment to the drug manufacturing company sponsoring an assistance program. Your signature is required on certain forms that allow this disclosure. Once we disclose the health information, it may no longer be protected by privacy laws.

By signing this authorization, you authorize the reimbursement specialist(s) to sign any and all forms and applications on your behalf and to access and release any personal demographic, diagnostic, therapeutic and/or financial information required to apply for drug manufacturing company medication/PAP assistance programs.

Furthermore, by signing this letter, you attest that the information you have provided is true and accurate. This information will remain confidential within Western Maryland Healthy system and only be released to the drug manufacturing company sponsoring the program in compliance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and state law. In accordance with Western Maryland Health System policy, failure to complete application for all other sources for which you may be eligible will result in pharmacy benefits being denied or canceled. Signing this form does not release you from any financial responsibility to Western Maryland Health System including, but not limited to, pharmacy dispensing fees.

None of the following information and/or records will be included in the use and/or disclosure: HIV/AIDS-related information, mental health information, genetic testing information, drug/alcohol diagnosis, treatment or referral information.

I, _____, hereby give permission for the reimbursement specialist to sign on my behalf when seeking aid from drug manufacturing company Patient Assistance Programs. I understand that I may revoke this authorization at any time by contacting the Western Maryland Health System PAP office at 240-964-1465.

Please print:

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone Number : _____ Alternate Phone Number: _____

Signature of Patient or Guardian: _____ Date: _____