Medication Name________________________________

Please complete the enrollment form and patient authorization section.
Once completed, fax to 1-866-216-5292.

1-800-745-2967
www.rrc.gsk.com

Patient Information

Patient Name:______________________________________ Date of Birth: _____ /______ /________ Preferred Language: ______________

Please present birthdate as: MM/DD/YYYY

Address:____

Phone (Home): (______)__________-______________ (Cell): (______)__________-______________

Insurance

Primary Rx Insurer: ____ Phone: (______)______-______________

Policy ID #: ____ Group #:___________________________

Secondary Rx Insurer: ____ Phone: (______)______-______________

Policy ID #: ____ Group #:___________________________

Physician Information

Physician Name: ____Tax ID__________________ State License ____________________

Address: ____ Phone: (_____)______-__________ Fax: (_____)______-_________

Financial Information (Complete only if you want help to determine eligibility for other sources of coverage or assistance)

Current Household Income:_________ Number of family members who rely on that income:______ Out-of-pocket medical expenses: ________

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE MEDICAL INFORMATION

I understand that the collection, use, and disclosure of my health information are protected under law. Information contained in this Enrollment Form, such as my name, address, insurance, prescription, and medical information, is "protected health information." By signing below, I agree to the collection, use, and disclosure of my protected health information as described below.

I understand that my healthcare providers will not condition my medical treatment on my agreement to sign this Patient Authorization and Release. I understand that once information about me is released based on this authorization, federal privacy laws may not prevent the entities described below from further disclosing my information. However, I understand that such entities have agreed to only use or disclose information it receives for the purposes described in this authorization or as required by law. I understand that this authorization will remain in effect for 180 days or until my coverage, coding, reimbursement, or other inquiry has been resolved, whichever is longer.

I also understand that I have the right to revoke this authorization at any time by calling 1-800-745-2967 and mailing a signed written statement of my revocation to PO Box 221425, Charlotte, NC 28222-0265, but that such a revocation would end my eligibility to participate in the program as described. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on this authorization. This means that, after you revoke this authorization, your information may be disclosed among GlaxoSmithKline ("GSK") and the company or companies that help GSK administer the programs in order to maintain records of your participation, but it will not be otherwise disclosed or used.

By signing below, I authorize GSK, as well as the Lash Group and any other companies that GSK uses to administer the RRC, to do the following:

1) Request and receive from my doctor, healthcare provider, health insurer, or pharmacist information necessary to investigate and resolve my coverage, coding, or reimbursement inquiry;
2) Collect, use, and disclose to each other any information that I provide to the RRC to investigate and resolve my coverage, coding, or reimbursement inquiry or to administer the RRC;
3) Disclose to my treating physician, healthcare professional, or pharmacist information I have provided when necessary to resolve my coverage, coding, or reimbursement inquiry. By signing below, I also authorize my insurer, doctor, healthcare provider, and pharmacist to release information about my prescribed medications and medical condition requested by GSK and the Lash Group;
4) Contact my insurer, other potential funding sources, social workers, patient advocacy organizations, patient assistance programs offered by GSK , on my behalf to determine if I am eligible for health insurance coverage or other funds, and disclose to them information about my prescribed medications and medical condition that has been provided by me or my physician, healthcare provider, or pharmacist; and
5) Disclose any information obtained from the sources listed above to third parties if required by law.

Patient Name (print):____ Date: ______ /______ /______

Signature of Patient or Authorized Patient Representative:____

Relationship (if other than patient): _____________________________________ Patient e-mail: _________________________________

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