Patient Consent to Release Financial/Personal Information

I would like to participate in the MAP patient assistance program. I understand that in order to determine eligibility to participate in the patient assistance program, certain information about my medical and financial status is needed. **I certify that all information given is correct, to the best of my knowledge.** I agree to permit the release of information to MAP and further agree that MAP may release this information in an attempt to obtain medication from assistance programs. I understand that these programs may be discontinued or modified at any time and I may not be permanently eligible to receive the medications. **I understand that I will be re-evaluated for eligibility in the MAP Program annually. During this annual re-evaluation it will be required/mandatory that I complete a MAP Renewal application and MAP Satisfaction Survey. These documents may be requested at separate times during the year, but must be completed and returned for continued/uninterrupted assistance.**

I agree to notify MAP in the event of any changes in my medical condition, financial status and/or health insurance coverage. Such changes may include:

- changes in medication dosage
- changes in insurance coverage
- changes in type of medication
- increase or decrease in income
- drug allergies or adverse drug reactions
- discontinuation of medication

______________________________________ ______________________________

Print patient name or legal representative **Date**

______________________________________ ______________________________

Patient signature **MAP Personnel/Witness**

Signature Permission Agreement

This Signature Permission Agreement will allow the Medication Access Program (MAP) representatives to act as your agent/patient advocate for the <u>limited</u> purpose of signing and submitting applications to patient assistance programs. **Your response to this will <u>NOT</u> affect your eligibility to participate in the MAP program.**

Please check <u>*one*</u> of the statements then sign your name below:

______ **Yes,** I will allow MAP's Medication Reimbursement Specialists to act as my agent for filling out, signing, and submitting application(s) to medication assistance programs.

______ **No,** I will not allow MAP's Medication Reimbursement Specialists to act as my agent for filling out, signing, and submitting application(s) to medication assistance programs.

______________________________________ ______________________________

Patient Signature **Date**