Patient Name: _____

PATIENT AUTHORIZATION

I understand that, before I may have communications with or receive assistance from the Cinnamon Helps Foundation (the "Program"), sponsored by Cinnamon Helps, Inc. ("Cinnamon Helps"), the administrators of the Program, including their contractors or other representatives, will need to obtain, review, use, and disclose my personal health information ("PHI"), including information relating to my medical condition and prescription medications and the information included in this patient enrollment form. I therefore authorize each of my physicians, pharmacies, and health plans to disclose my PHI, as necessary, to (i) Cinnamon Helps and the Program; (ii) the administrators of the Program, their contractors, third-party service providers, and representatives (collectively, "Program Administrators"); and (iii) the administrator of Cinnamon Helps' field access and reimbursement support team, its contractors, representatives, and third-party services partners (collectively, the "Field Access and Reimbursement Support Administrator") in order to (i) verify my eligibility to enroll in the Program; (ii) enroll me in the Program for which I am eligible; (iii) provide reimbursement support; and/or (iv) investigate other patient assistance solutions with the Program.

I also authorize Cinnamon Helps, the Program, the Program Administrators, and Field Access and Reimbursement Support Administrator, and their respective contractors to use, share, and disclose my PHI for the following purposes: (i) to provide the services described in this enrollment form; (ii) to communicate with me by U.S. postal mail, telephone, text, or email; (iii) to prepare summaries that do not include my PHI for statistical purposes; (iv) to conduct analyses to help Cinnamon Helps evaluate, improve, and/or provide its services, customer support, and educational and/or promotional materials for patients participating in the Program; and (v) to share my PHI with one another and to the extent applicable, with my physicians and pharmacists as well as with Medicare or Medicaid, my health plans, and their administrators, contractors, or representatives, in order for them to coordinate my benefits, provide, when applicable, reimbursement support, and investigate my insurance coverage.

I also authorize the Program Administrators and Field Access and Reimbursement Support Administrator to disclose my PHI to authorized representatives of Cinnamon Helps and the Program as necessary to ensure compliance with the rules of the Program. I also authorize Cinnamon Helps' authorized representatives to use my PHI to communicate with the Program Administrators, Field Access and Reimbursement Support Administrator, my physicians, pharmacies, and me for compliance purposes.

If I have designated a Legal Representative, I authorize Cinnamon Helps, the Program, Program Administrators, and Field Access and Reimbursement Support Administrator to use my PHI to contact the person I have designated as my Legal Representative for the purpose of verifying the information I have provided in this form and/or coordinating the provision of benefits that may be available to me under the Program, and to disclose my PHI to my Legal Representative for the purposes described in this authorization.

I understand that the PHI disclosed pursuant to this authorization, once disclosed, may not be governed by the same privacy laws and may be subject to re-disclosure, but I also understand that the administrators of the Program and their contractors and other representatives intend to use and disclose my PHI only for the purposes described in this authorization. I further understand that if I choose not to provide this authorization, I may not be able to receive any assistance from the Programs for which I may be eligible.

I understand that I may cancel this authorization at any time by telephoning Cinnamon Helps at **402-230-7282**, sending an e-mail to **Samary@cinnamonhelps.org**, or by mailing a written request for cancellation to **Cinnamon Helps Inc. 1309 S 204th St, PMB 220, Elkhorn, NE 68022**. I understand that canceling my

authorization will mean that my physicians, pharmacies, and health plans, as well as the Field Access and Reimbursement Support Administrator, Cinnamon Helps, the Program, and the Program Administrators may no longer rely on the authorization to use or disclose my PHI, but that any use or disclosure of such information that occurs before my cancellation is received will be unaffected by my cancellation.

I understand that if I do not cancel this authorization, the authorization will expire 15 months from the date of signature (or the maximum period allowed by applicable state law, if less than 15 months). The administrators of the Program will retain the information I have submitted in accordance with Cinnamon Helps' records retention policy. I understand that I am entitled to receive a copy of this authorization once it has been signed and may request a copy by contacting Cinnamon Helps at the contact information provided above.

By signing, I certify that I have read and agree to the above Patient Authorization based on the support I have requested.

Signature of Patient, Parent,
Legal Guardian or Legal Representative*: _____ Date: _____
*A legal representative is a person who has legal authority under applicable state law to bind you (the patient) by signing each authorization or declaration in the enrollment form.
Name of Signing Party (Please Print): _____

DECLARATION OF LEGAL REPRESENTATIVE (If Applicable)

I declare that I am the legal representative of the patient and that I have the legal authority under applicable state law to bind the patient by signing each authorization or declaration in this enrollment form.

Phone Number of Legal Representative:_____

Relationship of Legal Representative to Patient:_____