SigmaPharm LABORATORIES

SIGMAPHARM'S ACITRETIN CAPSULES, USP

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I authorize the use or disclosure of health information about me as described below.

1. I agree to permit my doctor and Sigmapharm Laboratories, LLC, its affiliates, and those working with Sigmapharm Laboratories or its affiliates (Sigmapharm) to use and disclose health information about me.

2. I agree to permit Sigmapharm to receive the following health information about me: All health information related to reimbursement of certain costs related to lab work and physician counseling, and health information in my medical records that is relevant to my treatment with acitretin.

3. Sigmapharm is authorized to use the information to determine if I qualify for reimbursement under the P.P.E.T: Pregnancy Prevention is Essential with Treatment program and, if it is determined that I qualify, in providing my doctor reimbursement for certain approved costs.

4. I understand that Sigmapharm is not a health care provider or health plan covered by federal privacy regulations, and when the information described above is disclosed to Sigmapharm it will no longer be protected by these regulations.

5. I understand that I may refuse to sign this authorization. If I do not sign, however, I understand that I will not be able to apply for or receive reimbursement of certain costs under the P.P.E.T. program.

6. I understand that I may revoke this authorization at any time by sending a written request to Sigmapharm Laboratories, LLC, Attn: P.P.E.T. Program, PO BOX 162, Morrisville, NC 27560, except to the extent that action has been taken in reliance on this authorization.

7. This authorization expires 1 year after my participation in the P.P.E.T. program ends.

_____ _____

Signature of patient or representative Date

_____

Patient name

_____ _____

Name of personal representative (if applicable) Relationship to patient

(A copy of this signed form will be provided to the patient.)

Patient Copy

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