# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

***Patient instructions:*** *Please read the authorization and fill in the information below, including your signature and today's date. You should keep a copy given to you by the office.*

I authorize my healthcare providers, pharmacies, insurers, and testing laboratories (my "Healthcare Companies") to disclose information about me, my medical condition, treatment, insurance coverage, and payment related to my use of AbbVie products ("Personal Information"), to AbbVie, its affiliates, collaborators, and agents (collectively "AbbVie"), to provide me with AbbVie-sponsored patient support and for AbbVie's analytics and research purposes. Personal Information released under this Authorization is subject to re-disclosure by AbbVie and will no longer be protected by HIPAA. My Healthcare Companies may receive remuneration from AbbVie for disclosing my Personal Information to AbbVie and contacting me about my use of AbbVie products and services. I am not required to sign this Authorization and my Healthcare Companies will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. This Authorization will expire in 10 years or a shorter period if required by state law, unless I cancel it sooner through https://www.abbvie.com/privacy-inquiry.html or by writing to AbbVie Privacy Office, 1 North Waukegan Road, North Chicago, IL 60064. Cancelling my Authorization will not affect uses of my information that occurred before my cancellation was received.

*I verify the information provided is true and correct. If I am the caregiver/representative of the patient, I confirm I am authorized to sign on behalf of the patient.*

*(Fields marked with * are required)*

*First name: Middle initial

*Last name: *Gender:

*Date of birth: (MM/DD/YYYY) *Phone number:

*Address Line 1:

Address Line 2:

*City:

*State: *ZIP code:

*Signature: *Date:

Representative name (print, if applicable):

Email:

FOR OFFICE ONLY: FAX the signed authorization to 1.678.727.0690.
Provide patient with a copy of this signed document.



COMPLETE by abbvie