SPRcare®

# Patient Consent & Release of Protected Health Information and Appointment of Representation

HIPAA Privacy Rule, 45 C.F.R. §164.508(c)(1)

***This authorization form must be completed in its entirety – incomplete forms will not be accepted.***

**Authorization for Release:** I, _____ (**FIRST AND LAST NAME**),

_____ (**DOB**) hereby authorize

_____ (**DOCTOR AND/OR PRACTICE NAME**) at to release the following information to SPR Therapeutics®, Inc. (SPR) for the purpose of providing patient access support through its SPRcare® Patient Access Program (SPRcare) in connection with securing insurance coverage for my treatment with the SPRINT® PNS System: (i) MEDICAL RECORDS: Hospital and Clinic medical records and notes, including but not limited to; doctor, nurse, physical therapy records and notes; tests and test results; all correspondence and records of any kind which pertain to my medical care, treatment history and prognosis; and (ii) INSURANCE/BILLING RECORDS: Member or Provider appeals/grievances; enrollment and benefit information; any and all communications, notes, claim forms, or other documents to/from insurance companies, self-insured plans, TPA's, claims administrators, Plan Sponsors, Plan Administrators, utilization review companies or other third-party payers involved with evaluating, adjusting, processing or paying my claim(s) for insurance benefits, whether pre-service or post-service in nature.

I understand that this authorization is voluntary and that my treatment, payment for my treatment, enrollment or eligibility for benefits is not conditioned upon whether I sign this form. I understand that: (i) the information that I authorize the practice to disclose may currently be protected by the federal and state privacy laws, such as HIPAA; (ii) once my information is disclosed to SPR, it may not be protected by these laws, and (iii) to the extent that SPR discloses the information to others, it may be redisclosed. I understand that my records may contain sensitive information, such as information regarding my mental health, substance use or dependency, or sexuality, and may contain confidential HIV/AIDS related information. Copies of this Consent and Release shall be treated in all respects as though an original, including facsimile transmissions. I have been advised of my rights to receive a copy of this Release.

This Authorization will expire on the later of one year from the date entered below OR upon conclusion of any appeal efforts being undertaken by SPR. I understand that I may revoke this Authorization at any time by notifying SPRcare in writing; and if I do, it will not affect any actions taken before my revocation.

**Appointment of SPR as Authorized Representative:** I hereby designate and appoint SPR to act as my Authorized Representative(s) and advocate with respect to my insurance plan, to assist me with seeking coverage for my therapy with the SPRINT® PNS System, and, if applicable, the appeal of my insurance denial, and, as such, to sign any authorization or appeal forms on my behalf that are required by my insurance plan. I understand that I am not establishing an attorney-client relationship with SPR Therapeutics or its representatives, and that I may revoke this Appointment at any time by notifying SPRcare in writing; and if I do, it will not affect any actions taken before my revocation.

I understand that SPR (i) has not provided me with any guarantee or assurance that I am eligible for the SPRcare program; (ii) has not promised me that I will obtain insurance coverage for my therapy; (iii) may decline, in its sole discretion, at any time, to pursue coverage for me; and (iv) will not subsidize my care. Entering into this arrangement will not alter any financial responsibilities I have to my health care provider or any other third-party. I understand that I may be asked to cooperate with SPRcare in its efforts to secure coverage, and that my failure to do so may negatively affect the outcome. While I understand there are no costs for me to participate in SPRcare, some third parties may require payment for copying records. Accordingly, I understand if I want those records to be a part of my appeal, I will be responsible for paying those costs.

I understand that in the course of my interactions with SPRcare I may share information about me and my health, including baseline and outcomes data. I understand that when I elect to do this, I am providing the information to SPR Therapeutics and not to a provider of health care services, and that the information is, accordingly, not protected by privacy laws applicable to communications with health care providers and health records, such as HIPAA. I hereby consent to SPR Therapeutics use of any such information to advance its business objectives. This consent to share and use any information that I have provided to be provided to SPR Therapeutics is permanent and irrevocable.

For additional information regarding how your personal data is used or collected (including your rights and notice for California residents), please see SPR's Privacy Policy at sprtherapeutics.com/privacy-statement/

**Please send completed form to SPRcare: Fax:** 216.649.0635 **Email:** SPRcare@SprintPNS.com

If you have questions: Call 833.SPR AUTH (833.777.2884)

**Patient Signature:** _____ **Printed Name:** _____

**Date:** _____ **Phone Number:** _____