Authorization to Use and Disclose Health and Other Personal Information

Patient's Name _____

Address _____

Home Phone _____ DOB _____/_____/_____

I authorize my physician and his/her staff to disclose my health and other personal information, including, but not limited to, the information on this form, to EMD Serono, Inc. and its agents and representatives including any company that helps administer EMD Serono's Compassionate Care Program (collectively "EMD Serono") so that EMD Serono may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to:

(1) contact me by mail, e-mail, and/or telephone to enroll me in, and administer EMD Serono's Compassionate Care Program;

(2) provide me with materials relating to EMD Serono's Compassionate Care Program;

(3) verify the accuracy of the information I provide in my application for EMD Serono's Compassionate Care Program;

(4) conduct surveys to measure my satisfaction with EMD Serono's Compassionate Care Program; and

(5) for such other purposes as may be required or permitted by applicable law.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to EMD Serono in order to assist EMD Serono in accomplishing the purposes described above.

I understand that once my information is disclosed pursuant to this authorization, there is no guarantee that it will not be disclosed to another third party. However, I understand that EMD Serono will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent.

PATIENT MUST SIGN THE BACK OF THIS FORM THEN SEND OR FAX BOTH PAGES

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive EMD Serono Products, but it will limit my ability to participate in EMD Serono's Compassionate Care Program.

I understand that this authorization will remain in effect for ten years from the date of my signature, unless I revoke it earlier by contacting EMD Serono or its representatives in writing by mail or fax at 6501 Weston Parkway, Suite 370, Cary, NC 27513, fax (919) 415-2870. If I revoke this authorization, EMD Serono will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I understand that the services provided by EMD Serono that are described in this authorization can be changed at any time, without prior notification.

I also understand that I have the right to receive a copy of this authorization.

Patient name (please print): _____

Signature of patient (or personal representative): _____ Date: ___/___/_____

Authority/relationship of personal representative (if applicable): _____

Signature of patient (or personal representative): _____ Date: ___/___/_____

Authority/relationship of personal representative (if applicable): _____

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