

Patient Authorization Form

*Required field. All sections to be filled out and signed by patient or guardian.

Patient Information		
*First Name:	*Last Name:	Email:
*Date of Birth (MM/DD/YYYY):	*Phone:	Cell Phone:

Patient Authorization to Use and Disclose Protected Health Information ("Authorization")

I authorize my healthcare providers and staff, pharmacies, health insurer(s), health plans or programs that provide me health benefits to disclose any and all necessary information, including but not limited to my Protected Health Information (PHI) (collectively, "Personal Information") included on the RYZUP Support Services Patient Enrollment Form as well as information related to my medical condition and treatment, health insurance coverage and claims, and prescription medications, to Avadel CNS Pharmaceuticals, LLC (d/b/a RYZUP Support Services) and its affiliates, agents and representatives, including its third-party patient support program service provider (hereinafter collectively, "Avadel") to provide me with access to services related to my prescribed medication and/or medical condition (the "Program"). I understand that my pharmacy providers may receive remuneration for using or disclosing my protected health information pursuant to this authorization.

Specifically, I authorize Avadel to receive, use, and disclose my Personal Information to (i) enroll me in the Program; (ii) conduct benefits investigation(s) and coordinate my insurance coverage, which may include allowing an Avadel field based representative to access my Personal Information and engage with my healthcare providers and health insurer(s) directly, if necessary; (iii) if needed, determine my eligibility for and coordinate financial assistance; (iv) coordinate prescription fulfillment and product replacement; (v) facilitate quality and adverse event reporting activities; (vi) conduct data analytics and Program-related business activities; (vii) provide Program educational materials and information; (viii) contact me by mail, telephone, text or email or to any future contact information provided by me or on my behalf in connection with carrying out the Program services, including adherence related communications, reminders and support, for which my pharmacy providers may receive financial remuneration from Avadel.

I understand that any Personal Information disclosed pursuant to this Authorization, once disclosed, will no longer be protected by federal privacy and security laws or applicable state laws. I understand that if I choose not to provide this Authorization, I will not be able to participate in the Program, but I will still be eligible for healthcare treatment and insurance benefits. I understand I may cancel this Authorization at any time by calling RYZUP Support Services at 1-844-485-7636 or by mailing a written request for cancellation to RYZUP Support Services, P.O. Box 7613, Overland Park, KS 66207. I understand that canceling my Authorization means my healthcare provider, pharmacies, and health plans, as well as Avadel, may no longer rely on the Authorization to use or disclose my Personal Information, but it will not affect previous disclosures by them pursuant to this Authorization. If I do not cancel it, this Authorization will remain in effect until I am no longer participating in the Program or until the Authorization is required to be terminated (i.e., if a shorter time frame is required by applicable law). I understand that I am entitled to receive a copy of this Authorization. By signing below, I acknowledge that I have read and agree to the Patient Authorization above.

*Patient/Guardian Signature

*Date

*Printed Patient/Guardian Name (First and Last)

Relationship, if applicable

- ☐ **Marketing Communications Opt-in (Optional):** By checking this box, I certify that I am at least 18 years old and consent to receive marketing, educational and informational communications from Avadel, its affiliates and agents by direct mail, email and to the phone number I provided, including text messages, prerecorded messages and phone calls, which may be sent via autodialer, to provide me with information about Avadel products, services, and programs or other topics of interest, including to conduct market research. I understand my consent is not a condition of purchase of my prescribed medication. Text and data rates may apply. I may opt out at any time by texting "STOP". Additional terms apply: <https://www.avadel.com/terms-and-conditions>.

