Authorization for Use and Disclosure of Protected Health Information

To the Patient

Intrinsic Therapeutics assists patients in obtaining insurance coverage for and reimbursement for the Barricaid Annular Closure Device procedure. In order to provide these services, Intrinsic Therapeutics must obtain and share certain information about you from your doctor, other health care providers and each of your health insurers.

Please complete this authorization, sign and date it, and return it to your doctor as well as Intrinsic Therapeutics Barricaid Patient Access Program at Reimbursement@barricaid.com or by fax 844-288-2660.

By signing below, I hereby authorize each of my doctors, and other health care providers and each of my health insurers to disclose to Intrinsic Therapeutics my protected health information, including but not limited to information related to:

- My medical condition and medical treatment
- My address and telephone number
- Information about my health insurance coverage, including my insurance identifiers

Further, I authorize Intrinsic Therapeutics, to receive, access, obtain, use, disclose, share and maintain my protected health information, including, but not limited to, the information described above, in order to assist me in obtaining insurance coverage and reimbursement for the Barricaid Annular Closure Device procedure., including contacting me to the extent necessary.

By signing this authorization, I understand the following:

- Information disclosed under this authorization might be disclosed and this redisclosure may no longer be protected by federal privacy laws.
- I am not required to sign this authorization. My choice about whether to sign will not change the way my healthcare providers or insurers treat me.
- If I refuse to sign this authorization, I understand that this means I will not be able to receive the reimbursement support services described herein.
- Authorization will last until I am no longer receiving reimbursement support services from Intrinsic Therapeutics.

I understand that I may revoke this authorization at any time by mailing a letter to my doctor or other health care providers, or by contacting my health insurers. However, I cannot cancel actions that have already been taken by relying on this authorization.

Patient Signature: _____ **Date** _____

If personal representative, relationship to patient: _____

Patient Name (Printed): _____