



# Columbus Oncology & Hematology

*Serving Ohio Since 1987*

810 Jasonway Ave.  
Columbus, Ohio 43214-4359

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## COA PATIENT ASSISTANCE PROGRAM

### Patient Consent and Authorization

Columbus Oncology Associates, Inc. ("COA") operates a patient assistance support program to assist its current patients seeking medication discounts that exist from time to time ("Patient Assistance Program"). The Patient Assistance Program researches and identifies drug discount programs, including without limitation drug rebate programs and copayment savings programs owned or operated by drug manufacturers, third-party drug rebate programs, non-profit foundations and other advocacy organizations (collectively, "Savings Programs"), which patients may be eligible for medication discounts. When identified, the Patient Assistance Program delivers patient information to Savings Programs for the benefit of patients. Savings are directly transmitted to patients and are not routed through COHA. "Patient information" includes health data and financial information of the patient that is either in the custody of COHA or has been provided by the patient.

COHA offers the Patient Assistance Program to its patients at no charge, but may receive remuneration from the Savings Programs in exchange for disclosing health data and financial information to Savings Programs and/or for providing patients with support services. COHA operates the Patient Assistance Program in accordance with industry standards and commercially reasonable practices. Support provided through the Patient Assistance Program represents no statement, promise or guarantee by the Program. And, COHA makes no guarantee of drug discounts for patient participation in the Patient Assistance Program.

#### Consent to Participate

**I hereby consent to participate in the Patient Assistance Program for so long as I am a patient of COHA receiving drug therapy treatments. And, I hereby authorize COHA to use and disclose my health data and financial information, including without limitation my identifying health information, health insurance information, medical diagnosis and condition (including lab test results related to such diagnosis or supportive testing), prescription information, and name, address, and telephone number to any Savings Program to which COHA reasonably believes I may be eligible to benefit from drug discounts.**

**I understand** that COHA will use reasonable efforts to identify and seek drug discounts under Savings Programs on my behalf, and **I hereby agree** that in no event will COHA be liable for any damages resulting from or relating the Patient Assistance Program.

#### Authorization for Disclosure of PHI

**I authorize COHA to review and share my protected health information (PHI) with Savings Programs pursuant to the Patient Assistance Program. I understand** that there is a potential for the information to be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996, as amended (or HIPAA) and the regulations promulgated thereunder including, without limitation, the Privacy Rule (45 CFR Part 164).

My PHI may include:

- information provided on this form;
- healthcare records related to my treatment and health condition(s);
- payer-related information received from my health insurer;
- prescription, fulfillment, shipment, and other information provided by pharmacies or other sites of care; and
- information to help support my transition of care;



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My authorization and notice of release will remain in effect for as long as I am receiving drug therapy treatments as patient of COHA.

**I understand** that I may be requested to provide my written consent for continued participation in the Patient Assistance Program and authorization for the disclosure of health and financial data, including PHI, from time to time by COHA. **I understand** that COHA may receive payment from the Savings Programs for disclosing my PHI or operating the Patient Assistance Program.

No Effect on Treatment

I UNDERSTAND THAT SIGNING THIS CONSENT AND AUTHORIZATION FORM IS VOLUNTARY, AND THAT IF I REFUSE TO SIGN THIS FORM, IT WILL NOT AFFECT THE START, CONTINUATION, OR QUALITY OF MY TREATMENT FROM COHA.

Revocation

After I have signed this consent and authorization, I may withdraw it by calling COHA at (614) 442-3130 or by sending a written notice to Columbus Oncology Associates, Inc. The withdrawal goes into effect once it has been received by the Program. If I choose to not sign this authorization or I withdraw it after signing this form, the Patient Assistance Program will not be able to provide me with the support described above after the date of my revocation.

_____	____/____/____
Patient Name (Please Print)	Patient Date of Birth
_____	_____
Parent/Legal Guardian Name (Please Print)	Relationship to Patient
_____	____/____/____
Patient/Parent/Legal Guardian Signature	Date