PATIENT PRIVACY FORM

Authorization for Use or Disclosure of Health Information

I authorize the use or disclosure of health information about me as described below.

1. I agree to permit my doctor and Mylan Pharmaceuticals Inc., a Viatris Company, its affiliates, and those working with Mylan Pharmaceuticals Inc., a Viatris Company, or its affiliates to use and disclose health information about me.
2. I agree to permit Mylan Pharmaceuticals Inc., a Viatris Company, to receive the following health information about me: All health information related to reimbursement of certain costs related to lab work and physician counseling, and health information in my medical records that is relevant to my treatment with acitretin.
3. Mylan Pharmaceuticals Inc., a Viatris Company, is authorized to use the information to determine if I qualify for reimbursement under the *MyMAC* program and, if it is determined that I qualify, in providing my doctor reimbursement for certain approved costs.
4. I understand that Mylan Pharmaceuticals Inc., a Viatris Company, is not a health care provider or health plan covered by federal privacy regulations, and when the information described above is disclosed to Mylan Pharmaceuticals Inc., a Viatris Company, it will no longer be protected by these regulations.
5. I understand that I may refuse to sign this authorization. If I do not sign, however, I understand that I will not be able to apply for or receive reimbursement of certain costs under the *MyMAC* program.
6. I understand that I may revoke this authorization at any time by sending a written request to Mylan Pharmaceuticals Inc., a Viatris Company, Attn: Acitretin Reimbursement, PSRM, 5005 Greenbag Road, Morgantown, WV 26501, except to the extent that action has been taken in reliance on this authorization.
7. This authorization expires 1 year after my participation in the *MyMAC* program ends.

Signature of patient or representative _____ Date _____

Patient name _____

Name of personal representative (if applicable) _____

Relationship to patient _____

(A copy of this signed form will be provided to the patient)

Revised: 5/2022
AUDHIpt:R3
Patient Copy

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