

**Authorization to Share Health Information for Reimbursement
or Patient Assistance Programs Provider Instructions**

Patients must complete this form before they can participate in the Program.

I, _____, allow my doctor(s), any other health care providers, and my health plan or insurers to give medical information relating to my use or need for Procrit® (Epoetin alfa) to Lash Group. Lash Group runs the Reimbursement and Patient Assistance Programs (the "Programs") for Ortho Biotech Products, L.P., the marketer of Procrit and Orthovisc, and the maker of Doxil, and Leustatin.

This information can include spoken or written facts about my health and payment benefits I may have. It can include copies of records from my health care providers or health plans about my health or health care.

Lash Group and Ortho Biotech will use and give out this information to see if I qualify for the Programs and to run the Programs. People who work for and with Lash Group and Ortho Biotech may also see my information, but they may use it only to help me get assistance with the costs of my drugs. I understand that they will make every effort to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it.

This Authorization will last until I am no longer participating in the Programs. If I change my mind before that time, I can tell my health care providers and my insurers in writing that I do not want them to share any more information with Lash Group or Ortho Biotech, but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my health care providers or insurers have given to Lash Group and Ortho Biotech.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my health care providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the Programs.

Patient Sign Here: X _____ Date: _____

Patient Name: _____

If the patient cannot sign, patient's personal representative must sign below:

Patient Name: _____

By: _____
(Signature of person signing for patient)

Describe relationship to patient and authority to make medical decisions for patient

A copy of this form must be provided to the patient.