Qutenza® Reimbursement Support Services
Acorda QRSS
PO Box 220651
Charlotte, NC 28222
P: 877-900-6479, Option 3
F: 877-304-1045

HIPAA AUTHORIZATION TO DISCLOSE INFORMATION

In order for me to obtain services under the Qutenza Reimbursement Support Services program, I understand that Acorda Therapeutics, Inc., its affiliates and authorized agents administering the program (including third-party administrators) will need to, use and disclose information about me, my health insurance and my medical diagnosis and treatment. I request and authorize my physician, pharmacy and healthcare professionals and my health plan or insurance company to give Acorda Therapeutics, Inc.'s affiliates and authorized agents administering the program (including third-party administrators) information about me, my health insurance coverage and my medical diagnosis and treatment. This information may include spoken or written facts about my health and payment benefits as well as copies of medical records from my physician, pharmacy and healthcare professionals or my health plan or insurance company about my health or healthcare. If in the course of business, my information must be given to Acorda Therapeutics, Inc. including its third party administrators. I authorize that this be done. I understand that my physician, pharmacy, health care professionals, health plan, and health insurer may not condition treatment, payment, enrollment, or eligibility for benefits upon my signing this Authorization. This Authorization is valid for 10 years unless I notify Qutenza Reimbursement Support Services in writing that I withdraw it. If I change my mind before that time and do not want Acorda Therapeutics, Inc. to continue to share my health information, I may notify Acorda Therapeutics, Inc. of such revocation in writing, signed by me or on my behalf and delivered to Acorda Therapeutics, Inc., PO Box 220651, Charlotte, NC 28222. If I notify Acorda Therapeutics, Inc. in writing to stop sharing my health information, such notice will be effective upon receipt by Acorda Therapeutics, Inc. but will not change any actions that Acorda Therapeutics, Inc. or others took in reliance upon this authorization before my effective revocation of this authorization. I understand that there is a potential for information disclosed pursuant to this Authorization to be redisclosed by the recipient, after which such information will no longer be subject to protections afforded by the HIPAA Privacy Rule.

Print Patient Name: _____

Signature of Patient (or Guardian): _____

Date: _____ Print Guardian's Name (if applicable): _____

Relationship to Patient: _____

Patient's/Guardian's Street Address: _____

City/State/Zip: _____ Telephone: _____

Email Address: _____

Please fax the original to Qutenza® Reimbursement Support Services at 877-304-1045 and maintain a copy for your records.

12/16 QUT 5350