IMPRIS
ENGAGING IMMUNO-PROTECTION INTERVENTION STUDY

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

Study Title: Real-world assessment of AZD7442 efficacy in preventing SARS-CoV-2 infection in immunosuppressed cancer patients

My name: _____

My address:_____

My city, state, postal code:_____

My date of birth:_____

Last 4 digits of my Social Security number:_____

Name of my hematologist/oncologist:_____
(Name of the doctor who is prescribing my cancer treatment)

Address of my hematologist/oncologist:_____

City, state, and postal code of my hematologist/oncologist:_____

Telephone of my hematologist/oncologist: _____

Fax of my hematologist/oncologist:_____

Name of my healthcare center (if applicable)_____

Name of my pharmacy: _____

Address of my pharmacy:_____

City, state, and postal code of my pharmacy:_____

Telephone of my pharmacy:_____ **Fax of my pharmacy:**_____

Name of my health insurance company or claims processor:_____

Address of my health insurance company:_____

City, state, and postal code of my health insurance company:_____

Telephone of my health insurance company:_____

Fax of my health insurance company:_____

Identification No. of my health insurance company: _____

I hereby authorize any doctor, nurse, nurse practitioner, medical assistant, emergency room, urgent care center, virtual medical appointment center, hospital, clinic, pharmacy, pharmacist, healthcare center, and/or health insurance company or claims processor that may be involved in any aspect of my medical care to disclose or reveal to:

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MediMergent, LLC
Attention: AZD7442 (Evusheld™) Study
9210 Corporate Blvd
Suite 100
Rockville, MD 20850
Telephone/fax: (800) 757-7345

the following medical information that identifies me:

All the information in my clinical records, pharmacy records, and health insurance claims for the twelve (12) months prior and during the twelve (12) months following the date of this Authorization, including visits, discharge summaries, discharge instructions, medical orders, electrocardiograms, echocardiograms, ultrasounds, computed tomography scans, magnetic resonance imaging scans, bone scintigraphy scans, emergency room, history, and physical exam records, lab reports, medication records, nursing, nurse practitioner, and medical assistant notes, surgical reports, progress notes, treatment notes, treatment plans, radiography reports, medication dispensing information from pharmacies, and information from health insurance claims. This includes all information of this type related to drug or alcohol abuse treatments, genetic testing results, mental health (excluding psychotherapy notes), sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC), or human immunodeficiency virus (HIV). This information also includes all of my responses included in all of my surveys and profiles from the AZD7442 (Evusheld™) study.

The sponsor, American Oncology Partners of Maryland, P. A., and MediMergent, LLC, the company administrating the collection, storage, and analysis of the aforementioned information, will disclose (reveal) and use the information for the express purposes of the AZD7442 study. The study is designed to collect information related to the patient's cancer treatment and to the efficacy of AZD7442 in preventing COVID-19 infection. American Oncology Partners of Maryland, P. A. or MediMergent, LLC may also disclose the aforementioned information to AstraZeneca Pharmaceuticals LP, for purposes of evaluating the study results.

I understand that this Authorization will expire 18 months after the date of this Authorization.

I understand that I can revoke (withdraw) this Authorization at any time by giving notice in writing to each of the aforementioned parties. The revocation will take effect on the date when that party receives it, unless measures have already been taken by virtue of this authorization.

I understand that MediMergent, LLC may remove information that could or does identify me, from my above-mentioned medical information, and that the remaining information will no longer be subject to this authorization and may be used and disclosed for any legal purposes.

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I understand that the above-mentioned doctor, pharmacy, clinic, hospital, virtual medical appointment center, urgent care center, emergency room, insurance company, and/or claims processor must protect my medical information in compliance with the provisions of federal privacy laws. The federal privacy law (HIPAA) requires the people who receive my medication information under this Authorization to protect my information and not to share it with others without my permission, unless it is allowed by the laws that govern this exchange of information.

I understand that I am not required to sign this Authorization, but that if I do not sign it, I cannot participate in the aforementioned study on preventing COVID-19 with AZD7442. The above-mentioned doctor, pharmacy, clinic, hospital, urgent care center, emergency room, virtual medical appointment center, insurance company, or claims processor cannot in any way condition (withhold or refuse) medical treatment, payments, enrollment, or eligibility for benefits due to my signing this authorization.

I understand that I will receive a copy of this document after signing it.

I understand that I will not pay a fee for any disclosure, transfer, copy, and/or review of my medical information that may occur based on this Authorization.

It is requested that my medical records be disclosed from: Name of the doctor, pharmacy, clinic, hospital, urgent care center, emergency room, virtual medical appointment center, or records custodian:
Address:
City, state, postal code:

It is requested that my medical records be disclosed to: MediMergent, LLC
9210 Corporate Blvd.
Suite 100
Rockville, MD 20850

My signature below meets all the necessary conditions for compliance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA), the Federal Electronic Signature in Global and National Commerce Act (ESIGN Act), and the Uniform Electronic Transactions Act (UETA).

Signature: _____ Date:

_____

If a personal representative signs, a description of that representative's authority to act on my behalf is included below: (mark one option):

☐ Non-probate executor	☐ Executor of an estate	☐ Legal guardian	☐ Father or mother
☐ Beneficiary	☐ Holder of medical power of attorney		☐ Close family member