PATIENT HIPAA AUTHORIZATION

By signing this Authorization, I authorize any health plan (including my health insurance company) and my healthcare providers (including pharmacy providers) (respectively, "HEALTH PLAN", "PROVIDER" and "PHARMACY") to use and disclose my protected health information (as defined under the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Technology for Economic and Clinical Health Act), including but not limited to my name, social security number, contact information, birth date, medical and pharmacy records, information relating to my medical condition, treatment, and health insurance, as well as all information provided on any prescription and information relevant to my enrollment participation, or receipt of assistance under the PROLASTIN DIRECT Program (collectively, "Information"), including to Grifols, AlphaNet, Inc. ("AlphaNet") if consented, and any other third parties engaged to assist in administering the PROLASTIN DIRECT Program ("PROLASTIN DIRECT Partners") for the following purposes:

- To establish my benefit eligibility
- To enroll me in the PROLASTIN DIRECT Program
- To provide me with information about PROLASTIN-C LIQUID
- To provide me with other educational information related to my medical condition
- To communicate with my healthcare providers and health plans about my benefit and coverage status and/or medical care
- To evaluate the effectiveness of the PROLASTIN DIRECT Program
- To administer, evaluate, and improve the PROLASTIN DIRECT Program, including by analyzing usage patterns and effectiveness of Grifols' products, services, and programs and helping to develop new products, services and programs and for other Grifols general business and administrative purposes
- To assist me in obtaining payment for PROLASTIN-C LIQUID or other medications from my health plan or other programs
- To refer me to additional support services, if needed

I further authorize PROLASTIN DIRECT Partners to obtain, review, use, and disclose my information for the foregoing purposes. PHARMACY, PROVIDER or HEALTH PLAN is authorized to contact me by mail, e-mail, text, telephone, and/or any alternative communication method that I request for such purposes. I understand that PHARMACY and/or other healthcare providers may receive financial remuneration from Grifols to provide some of these communications to me and that the use and disclosure of my information as described in this Authorization may be considered use or disclosure for "marketing" under HIPAA. I authorize these uses and disclosures to the extent they are directly related to the PROLASTIN DIRECT Program, my prescription, services associated with my prescription, or other specialty pharmacy programs.

Once I sign this Authorization and my Information has been disclosed, I understand that federal privacy laws may no longer protect the information. I understand that I may refuse to sign this Authorization, and that doing so will not affect my ability to receive treatment with PROLASTIN-C LIQUID or obtain insurance or insurance benefits. I understand that I am entitled to a copy of this Authorization, and that

I may cancel this Authorization at any time, by mailing a letter requesting cancellation to: PROLASTIN DIRECT Program c/o **1680 Century Center Parkway, Suite 8, Memphis TN 38134.**

I understand that the cancellation shall be effective upon actual receipt of my letter by the PROLASTIN DIRECT Program. Canceling this Authorization will end further use and disclosure of my Information as authorized above after the date that the PROLASTIN DIRECT Program receives my letter but will not affect Information that has already been used or disclosed in reliance upon this Authorization.

This Authorization expires ten (10) years from the date this Authorization is signed unless a shorter time period is required under state law.

Patient Signature Date

Patient Name (Print)

Personal Representative Signature (if applicable) Date

Personal Representative's Printed Name

Relationship to Patient, including the authority for status as Personal Representative

Address of Patient or Personal Representative

Telephone Number of Patient or Personal Representative