HUMAN AMNIOTIC MEMBRANE ALLOGRAFT AMNIOEXCEL®

HUMAN AMNIOTIC LIQUID ALLOGRAFT AMNIOMATRIX®

**Consent and Authorization for Disclosure of Patients Health Information "PHI"**

I hereby: (1) authorize Argenta Advisors LLC, Argenta reSource Company, and their agents (Argenta) working on behalf of Derma Sciences, Inc. (Derma Sciences) to contact my healthcare provider, insurance company or other third-party payers about my medical, insurance or third-party information that is reasonable to use and disclose for the purposes of providing reimbursement support and/or helping to facilitate insurance coverage or payment for AMNIOEXCEL® or for AMNIOMATRIX®, human allograft tissues, as part of my wound treatment (2) authorize Argenta to disclose (i.e., release) all such information to Derma Sciences and/or its contractors for the purpose of providing reimbursement support. Information used for any other purposes will not include any information that identifies me directly, such as name, address, date of birth, etc.

**Terms of Authorization**

By signing below, I authorize the use and disclosure of my information as stated above. I understand that:

- Signing of this authorization and the provision of reimbursement support is not a guarantee of insurance coverage.
- Once my health information is disclosed to Derma Sciences or third parties, federal privacy laws may no longer protect the information. However, Argenta agrees to protect this information by using and disclosing it only for the purposes described within or as required by law. Information used for any other purposes will not include any information that identifies me directly, such as my name, address, date of birth, etc. These limitations continue even after the expiration or revocation of this authorization.
- I can refuse to sign this Authorization, but if I choose to, Argenta will not be able to provide reimbursement support and/or services.
- At any time, I may revoke this Authorization by notifying Argenta, Derma Sciences and my healthcare provider in writing that I no longer want to share information.
- Argenta, on behalf of Derma Sciences, reserves the right, at any time and without advance notice, to modify or discontinue any or all aspects for the program and terminate any assistance provided.
- I have the right to receive a copy of this form.

I understand that this authorization is valid for one year or until final insurance authorization is secured or all appeal options have been exhausted, whichever is later.

**PATIENT AUTHORIZATION**

Signature of Patient or Legal Representative　　　　Date

Print Name of Patient　　　　Patient's DOB　　　　Legal representative's relationship to patient