Duke University Medical Center
Pharmacy Patient Assistance Program
Patient Acknowledgement and Authorization

I will provide all of the information requested by the Duke Patient Assistance Program Advocate. I guarantee that all of the information I provide is complete and accurate. It is my responsibility to inform the Patient Assistance Program of any information or status change while on programs. I will allow the Advocate to obtain my personal, medical, income, and insurance information solely for the intent of assisting in enrollment and reapplying for the drug manufacturer's programs or individual foundation grants. I am aware that this will not be used for any other purpose.

I understand that each drug program is different. The program guidelines may change and in this event, I will have an alternative method of obtaining medications. It is my sole responsibility to ensure that I have the medications needed. I am aware that the Duke Patient Assistance Program is available to assist with the necessary paperwork and prescriptions. I will work with my Advocate to ensure all paperwork is completed. I understand that time is a factor when applying to the program and refilling medications.

I agree to abide by this information while enrolled to the Patient Assistance Program. If medication is not obtained while on site, shipping arrangements are available (and maybe at my expense)

This authorization will be kept in my file at all times. By signing this document, I hereby state that I have read and fully understand all the information.

Signature of Patient or Legal Representative Date

Printed Patient Name or Legal Representative Date