Patient Authorization Form

RYZUP™ SUPPORT SERVICES

*Required field. All sections to be filled out and signed by patient or guardian.

Patient Information

*First Name:	*Last Name:	
*Date of Birth (MM/DD/YYYY):	*Phone:	Email:

Patient Authorization for RYZUP Support Services and to Share Health Information

By signing this authorization, I authorize my healthcare providers and staff, my health insurer, health plan or programs that provide me health benefits, and any pharmacies that dispense my medication to disclose to Avadel CNS Pharmaceuticals, LLC and its affiliates and agents (together, "Avadel") my Protected Health Information (PHI), including information related to my medical condition and treatment, health insurance coverage and claims, and prescription medications and the information included in this RYZUP Support Services Enrollment Form. I understand that my pharmacy providers may receive remuneration for disclosing my protected health information pursuant to this authorization. My PHI may be disclosed orally or in writing, including by facsimile, email, and/or through other data transfer means.

Specifically, I authorize Avadel to receive, use, and disclose my PHI to (i) enroll me in and contact me about RYZUP Support Services; (ii) provide me with Avadel products and RYZUP Support Services educational materials, information, and services, including to communicate with me by mail, telephone, or email; (iii) prepare summaries that do not include my PHI for statistical purposes; (iv) share my PHI with others and with my physicians and pharmacists to coordinate my benefits and investigate my insurance coverage; and (v) disclose my PHI to authorized representatives of Avadel as necessary to ensure compliance with the rules of RYZUP Support Services. I understand that Avadel may reach out to me to verify the accuracy of the information on this form and request additional financial and insurance information to assist in determining my eligibility for RYZUP Support Services and any specific services of the program, including financial assistance and affordability programs. I may be contacted by Avadel for medical research and related purposes to help develop new products, services, and programs or as necessary to comply with applicable laws including any safety reporting obligations.

I understand that any PHI disclosed pursuant to this authorization, once disclosed, will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that if I choose not to provide this authorization, I will not be able to participate in RYZUP Support Services, but I will still be eligible for treatment, product, and health insurance benefits. I understand I may cancel this authorization at any time by calling RYZUP Support Services at 1-844-485-7636 or by mailing a written request for cancellation to RYZUP Support Services, P.O. Box 7613, Overland Park, KS 66207. I understand that canceling my authorization means my physicians, pharmacies, and health plans, as well as Avadel, may no longer rely on the authorization to use or disclose my PHI, but it will not affect previous disclosures by them pursuant to this authorization. This authorization will remain in effect until I am no longer participating in RYZUP Support Services or until the authorization is required to be terminated (ie, if a shorter time frame is required by applicable law), from the date of my signature unless otherwise canceled earlier as set forth above. I understand that I am entitled to receive a copy of this authorization.

By signing, I certify that I have read and agree to the above Patient Authorization.

_____ _____

*Patient/Guardian Signature *Date

_____ _____

*Printed Patient/Guardian Name (First and Last) Relationship

☐ **Additional opt-in:** By checking this box, I authorize Avadel and third-party companies working on their behalf to contact me by mail, email, telephone, or text message for (i) marketing purposes, including to provide me with information about Avadel products, services, and programs or other topics of interest; and/or (ii) to conduct market research. I acknowledge and agree that the text messages may contain PHI. Text messaging is not a secure method of communication and carries some risk of being read by a third party. Message frequency may vary, and data rates may apply. Reply STOP to cancel text communication, or reply HELP for help. Full Terms and Conditions can be found at https://www.avadel.com/terms-and-conditions along with our Privacy Policy at https://www.avadel.com/privacy-policy. Avadel reserves the right to modify or amend the Terms without prior notice. Continued enrollment in RYZUP Support Services will mean you accept those