MannKind Cares℠

Please call toll-free **(844)-3-AFREZZA** with any questions. Fax to: **(800) 561-6174**

afrezza®
(insulin human) Inhalation Powder

Patient Authorization

Patient (First and Last Name):

Address:

Home # (required):

Email: DOB:

AUTHORIZATION TO USE AND DISCLOSE HEALTH AND OTHER PERSONAL INFORMATION

I authorize my physician and his/her staff to disclose my health and other personal information, including, but not limited to, the information on this form, to MannKind Corporation and its agents and representatives (collectively "MannKind") so that MannKind may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to:

1. facilitate the filling of prescription for and the delivery and administration of AFREZZA® [insulin human] Inhalation Powder;
2. assist me in obtaining insurance coverage for AFREZZA®;
3. contact me by mail, email, and/or telephone to enroll me in, and administer, programs that provide AFREZZA® support services;
4. provide me with free educational information and materials;
5. conduct surveys to measure my satisfaction with AFREZZA® and AFREZZA® support services; and
6. contact me about participating in clinical trials and market research.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to MannKind in order to assist MannKind in accomplishing the purposes described above. I understand that once my information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws (the Health Insurance Portability and Accountability Act) or state privacy laws and may be further disclosed to others. However, I understand that MannKind will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent. I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive AFREZZA®, but it will limit my ability to receive support services for AFREZZA®.

I understand that this authorization will remain in effect for ten years from the date of my signature, unless I revoke it earlier by contacting MannKind. If I revoke this authorization, MannKind will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization. I understand that the services provided by MannKind that are described in this authorization can be changed at any time, without prior notification. I understand that certain Third Parties may receive compensation in exchange for their disclosure of my information to MannKind.
I also understand that I have the right to receive a copy of this authorization.

Patient name (please print):

Signature of patient (or personal representative): Date:

Authority/relationship of personal representative (if applicable):

Signature of patient (or personal representative):

Authority/relationship of personal representative (if applicable): Date:

MannKind Contact (if applicable)

Print Name: _____

For CDE HELP TEAM Use Only[1]

☐ Patient has attended a product training session

☐ CDE HELP Team[2] ☐ Sales Professional

[1] MannKind or its Agents will only text you with your permission. Standard text message and data rates apply.

[2] "Certified Diabetes Educator"and "CDE" are certification marks owned and registered by the National Certification Board for Diabetes Educators, or NCBDE. NCBDE is not affiliated in any way with MannKind Corporation. NCBE does not sponsor or endorse any diabetes-related products or services.