PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION FOR INSURANCE PRE-DETERMINATION

I _________________________(patient name) authorize my health care providers and health insurance plan, to disclose to Sirtex Medical Pre-determination personnel, information about my medical history, recent diagnoses, past treatment and treatment now being proposed by my health care provider, and my insurance coverage including any coverage limitations. Specifically, I authorize the release of a recent history and physical, the past six months' of clinical notes from my referring physician and a consult note from my treating physician. I authorize this release of my protected health information ("PHI") for the purpose of allowing Sirtex Medical Pre-determination personnel to assist in determining if SIRT (Selective Internal Radiation Therapy) with SIR-Spheres microspheres is a covered benefit under the terms of my health plan policy.

Further, if necessary, I consent to being contacted by Sirtex Medical Pre-determination personnel for the purpose of obtaining additional information to support the authorization or appeal process for treatment with SIR-Spheres microspheres. I understand that Sirtex Medical will take reasonable steps to protect my PHI and will only disclose my PHI to my health insurance plan and Sirtex's pre-determination personnel.

I understand that I may refuse to sign this authorization and that refusing to sign the authorization will not affect my care from any health care provider. I further understand that I may revoke this authorization in writing at any time. Written revocation requests should be directed to Desiree Gray, Director of Health Economics & Patient Advocacy, Sirtex Medical Inc., 300 Unicorn Park Drive, Woburn, MA. 01801. I acknowledge, however, that it may not be possible for Sirtex Medical to retrieve information that was disclosed prior to receiving a revocation notice.

Sirtex Medical's Pre-determination program assists healthcare professionals to investigate insurance plan benefits and determine coverage by third party payers based upon the coverage guidelines established by the plan and the medical information provided by my health care providers. Third party reimbursement is based upon a number of factors and Sirtex Medical makes no representation or guarantee that insurance reimbursement or any other payments for treatment with SIRT will be available.

This authorization will be valid for a period of one (1) year from the date of signature.

I have read and understand this authorization:

Patient Name (please print) ____

Patient Signature _________________________________ Date _________________

Witness ____ Date _________________

Relationship to Patient __________________________