ANDOVER EYE

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CONFIDENTIAL

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

You are being asked to sign this Privacy Authorization Form to allow Ora, Inc. access to protected health information (PHI). Ora, Inc. is an internationally renowned clinical research and development group that specializes in the development of ophthalmic (eye), topical medications and medical devices.

In order to determine if you are qualified for and/or interested in participating in clinical research trials that Ora might conduct, you will need to agree to the terms of this authorization.

I, _____, authorize Ora, Inc. and/or their administrative and clinical staff to use and disclose the PHI listed above to sponsoring drug companies or contract research organizations.

This authorization is to allow Ora, Inc. to use the information above to determine if you may be eligible for future research studies. Prior to disclosing any other PHI (like your past or present medical conditions or medications you are currently taking) for a study Ora will ask for your authorization and you would be asked to sign a separate Authorization similar to this.

This Authorization is for research and has no expiration date.

You have the right to revoke this authorization, in writing, at any time by sending a written notification to Ora's Privacy Contact at PrivacyContact@oraclinical.com or:

Ora, Inc.

300 Brickstone Square

Andover, MA 01810

There will be no re-disclosure of your PHI by Ora until you have signed a further authorization.

Ora will not condition treatment, payment, enrollment or eligibility for benefits (as applicable) on whether or not you provide authorization to release your protected health information to Ora unless your treatment is related to research conducted with Ora.

If you choose to sign this form, you will receive a copy of this signed authorization for your records.

_____ _____

Printed Name of Patient or Legally Authorized Representative Date

_____ _____

Signed Name of Patient or Legally Authorized Representative Date

_____

Description of Legally Authorized Representative Authority

 Rev. 09/2004

THIS IS AN IMPORTANT DOCUMENT. PLEASE KEEP A COPY FOR YOUR RECORDS.