understand that in the event I qualify for a Program(s), I may need to reapply periodically and sign a similar authorization as part of such reapplication. I certify that the Personal Information that I have provided to Moffitt is true and complete, and I understand that Moffit will be providing this Personal Information to the Programs. I agree that, at any time during my participation in any Programs, Moffitt may request additional documentation to verify my Personal Information. If there is missing information or I do not respond to requests for additional documents, my participation in the Program(s) may be delayed or I may no longer be able to participate. If I qualify for and receive co-pay assistance, free medication assistance, or any other assistance from the Programs, I agree to comply with all Program rules from which I receive assistance. I also agree that I will not get reimbursed for the Program assistance I receive from anyone else, including from an insurance program, another charity, or from a healthsavings, flexible spending, or other health reimbursement account. I understand that assistance may be temporary. I will contact Moffitt if my insurance or treatment changes in any way. I further understand that I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to the Programs.

By checking the "Consent & Authorization" box below, I agree and acknowledge that I have read and understand this voluntary authorization and consent, and that I authorize Moffitt through its authorized agents to complete and submit the Program applications on my behalf utilizing my Personal Information. I understand that this Personal Information may be obtained from me, my Moffitt physicians and other care providers, my Moffitt medical record, my health plans, and other sources. I understand that application to the Programs is voluntary and that if I refuse to apply, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to the Programs.

☐ Consent & Authorization

_____ Patient Signature