Authorization for Release of Health Information Pursuant to HIPAA

By signing this authorization, I authorize my health plans, physicians, long-term care and other healthcare providers, pharmacies, and health insurance companies, and each of their respective representatives, employees, staff, and agents (collectively "Providers") to use and disclose my Protected Health Information ("PHI"), which is defined to mean all information regarding my health care, including but not limited to, my name, address and phone number, information relating to my medical condition, treatment, care management, and health insurance, as well as information provided on this form and any prescription to Tarsus Pharmaceuticals and its representatives or agents (collectively "Tarsus"). I authorize and direct my Providers to use my PHI to make disclosures of PHI to Tarsus for the following purposes:

- Reimbursement support associated with the filling of my prescription for XDEMVY™ (lotilaner ophthalmic solution) 0.25%, including the performance of an insurance verification and assisting in securing of any insurance coverage for XDEMVY to which I am entitled.
- Facilitating the provision of patient assistance, reduced cost medication and/or other XDEMVY-related services offered by Tarsus.
- Receiving marketing and promotional communications related to my disease condition, XDEMVY, and other information from Tarsus via the contact information I have provided.

With respect to any disclosures by my pharmacies, I understand that my pharmacies will receive remuneration (payment) from Tarsus for making disclosures of PHI and/or support services to Tarsus.

I understand that once my PHI is disclosed under this authorization, it is no longer protected by Federal privacy laws, including HIPAA, and may be further disclosed by Tarsus.

I understand that I may refuse to sign this authorization and that treatment, payment, or eligibility for benefits is not conditioned on my signing this authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the Tarsus Connect insurance support services (should I qualify).

I understand that this authorization is valid for a period of 10 years or for a shorter period dictated by applicable state law.

I understand that I may cancel (revoke) this authorization at any time by mailing a letter requesting such cancellation to Tarsus Connect at P.O Box: 220645, Charlotte, NC 28222, but that this cancellation will not apply to any information already used or disclosed through this authorization before notice of the cancellation is received by my Providers.

_____

Name (please print)

_____

Signature

_____

Describe Relationship to Patient and Authority to Sign if Not the Patient

___/___/_____

Date

tarsus