Office Attestation Form

Amgen Access professionals assist patients with patient access issues, including by educating providers on the process of claims submissions, local and regional payer requirements, and coding issues. In particular, they are trained to serve patients by helping providers navigate individual patient access issues for Amgen products. As part of these activities, they will likely need access to Protected Health Information (PHI) as defined under the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), including the patient's demographic information, medical history, health care plan benefits, and/or limits or restrictions on payments covered by the patient's health care plan policy. This information will be used for the purposes described above and related activities.

Amgen and its contractors and business partners respect patients and take seriously the obligation to protect their privacy. Accordingly, the Amgen Access professionals will follow your applicable patient privacy policies and procedures that you have established in compliance with HIPAA and applicable state privacy laws.

By signing below, you represent that they may review, discuss and use select PHI with physicians, nurses, physician assistants and staff for the office listed below for the purposes described above, and you acknowledge that such disclosure of PHI to the Amgen Access professionals is for purposes of helping enable your treatment of the patient whose PHI is disclosed, in accordance with any applicable exceptions under HIPAA, as well as the relevant patient privacy authorization which you obtain and maintain from such patient whose PHI is disclosed for these purposes.

Office: _____ Date: _____

Office Address: _____

Name: _____ Title: _____

Signature*: _____

* By signing here you acknowledge that you are signing on behalf of your office.