PYROS™
TOTAL CARE

Patient Authorization

Patient Name

Date of Birth

Protected Health Information

Pyros Pharmaceuticals, Inc., ("Pyros") may provide useful patient information or updates about pharmacy services and other offerings. Pyros and its affiliates may contact me through email, direct mail, telephone, or text messaging (SMS). I understand that my wireless service provider's message and data rates apply. I agree that Pyros may contact me for the purpose of soliciting my opinions on products, programs, and services. Pyros respects your personal information. However, I understand that my information, once disclosed under this authorization, may no longer be protected by state or federal privacy laws, and could be further disclosed. We encourage you to read our Privacy Notice at www.pyrospharma.com/privacy-policy.

Text Messaging

Anovo Pharmacy would like your permission to send you important pharmacy information regarding the patient's prescription via text message (SMS). These notifications will not be marketing communications about your medication and will not include Protected Health Information. Providing authorization to receive text message notifications from Anovo is voluntary and is not required to receive pharmacy services from Anovo. I understand that text messages will be sent to the cellular phone number provided and you have the authority to request messages to be sent to the cellular phone number. I understand that my wireless service provider's message and data rates apply.

Disclosure/Opt-Out

I understand that I have the option to decline signing this Authorization, and my access to treatment is not dependent on signing it. I understand that I am entitled to a signed copy of this Authorization. I understand that I may cancel this Authorization at any time by calling 1-888-760-8330 or by mailing a letter requesting such cancellation to AnovoRx Group, LLC, 1710 Shelby Oaks Dr., Ste 1, Memphis, TN 38134, which will convey the cancellation to any companies working with Pyros that have received the Authorization. I also understand that any such cancellation will not apply to any information already used or disclosed based on this Authorization before receipt of the cancellation by Pyros. This Authorization expires ten (10) years from the date signed below.

Please check the box(es) below to confirm acknowledgement and consent:

- ☐ I acknowledge and grant authorization for Pyros Pharmaceuticals to use and disclose my Personal Health Information to third parties for the purposes stated in the Protected Health Information section in this document.
- ☐ I acknowledge and grant authorization to Anovo Pharmacy to enroll me in the text messaging program to receive updates regarding the patient's prescription as stated in the Text Messaging section of this document.

Patient/Guardian Signature

Date

Patient/Guardian Print Name

Cell #

Email Address

Mailing Address