ANZ VERSION:
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SYNTACTX

Valiant Navion™ Thoracic Stent Graft System
SAFE-N LIMITED WARRANTY

Limited Authorization to Disclose Health Information
For SAFE-N Limited Warranty: Patient and Physician Support Program

To facilitate prompt and efficient reimbursement of expenses under the SAFE-N Limited Warranty Program, including any reimbursement for qualifying expenses paid by you, the patient, please complete and sign the form and submit to Syntactx. For any questions in completing this verification form, please contact Medtronic through Syntactx at the SAFE-N reimbursement helpline: AU: 1800 512 149, NZ: 0800 444 248 or email: SAFE-N-Reimburse@syntactx.com.

Patient Information

Patient Full Name: _____

Date of Birth: _____

Healthcare Provider

Provider Name(s) (please list all entities who may have information or documents related to your treatment for thoracic aortic disease): _____
_____
_____

I,_____, am the patient identified above that has been implanted with the Valiant Navion™ Thoracic Stent Graft System and am eligible for participation in the SAFE-N Limited Warranty Program ("Program"). For purposes of participating in this Program, I authorize my healthcare provider(s) to release and furnish the documents and information identified below to Syntactx LLC, Medtronic PLC, and/or their duly assigned agents:

- All medical records, including patient imaging and interpretations thereof, lab or test results, office and physician notes, operative recommendations, plans, and reports, and records received by or from other physicians, related to my care and treatment for thoracic aortic disease, including the implantation, use, surveillance, and any repair or reintervention related to the Valiant Navion™ Thoracic Stent Graft System.
- All pharmacy/prescription records including any drug information handouts/monographs related to my care and treatment for thoracic aortic disease.

- All billing records including all statements, itemized bills, and insurance records related to my care and treatment for thoracic aortic disease.

I understand that I may revoke this Authorization in writing at any time. Any revocation must be submitted in writing to Syntactx. This Authorization too shall expire one year after my date of death, unless I choose to revoke this authorization at an earlier date. I understand that any revocation will affect only future disclosures, not any disclosures made before Syntactx receives my written revocation.

I understand that my treatment, payment, enrollment, eligibility of benefits, or receipt of services from Syntactx is not conditioned on whether I sign this Authorization. If I have questions about disclosure of my health information, I can contact Syntactx with the contact information provided above.

I understand that this Program is voluntary and is not intended to be an admission of guilt or liability of any kind by the Program sponsors or a waiver by individuals participating in the Program. I certify that the statements and information contained herein or provided in this document are true, accurate, and complete. By signing this Authorization, I acknowledge that I have read and accept all of the above.

A notarized signature is not required. A copy of this authorization may be used in place of an original.

Print Name: _____(patient/representative) Date: _____

Signature: _____ Date: _____