

**Medtronic**  
Structural Heart and Aortic  
3576 Unocal Place  
Santa Rosa, CA 95403

**SYNTAX**

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

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

Please note that under federal regulations, an insurer or healthcare provider may use or disclose protected health information for its own treatment, payment, or healthcare operations. 45 CFR 164.506(c). 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 U.S. SAFE-N reimbursement helpline: 1-833-256-2308 or email: [SAFE-N-Reimburse@syntactx.com](mailto:SAFE-N-Reimburse@syntactx.com).

Patient Information

Patient Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Last Four Digits of SSN: \_\_\_\_\_

Disclosing Entity

Provider Name(s) (please list all entities who may have financial 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 the above listed entities to release and furnish the documents and information identified below to Syntactx LLC, Medtronic PLC, and/or their duly assigned agents, notwithstanding any otherwise applicable protection under the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") or other provision of law:

- All financial information and records, including written and oral communications related to any and all of my financial accounts, financial statements, billing records, itemized statements, billing history, payment history, agreements and correspondence, 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 insurance records, including documentation of insurance coverage, policies, claims, denials, benefits, write-offs, balances, and patient responsibilities, 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. I understand that any information disclosed as part of this Authorization may be further disclosed and may no longer be protected by federal or state privacy laws, including HIPAA. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. If I have questions about disclosure of my financial 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. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name: \_\_\_\_\_(patient/representative)      Date: \_\_\_\_\_

Signature: \_\_\_\_\_      Date: \_\_\_\_\_

Additional limitations may apply. Reimbursements are subject to review and approval. The SAFE-N Limited Warranty is limited to its express terms and does not constitute a representation, judgment, admission, or assumption of liability by Medtronic with respect to imaging, reintervention, and/or utilized thoracic stent graft systems. No action taken by Medtronic in connection with the Voluntary Product Recall, including this SAFE-N Limited Warranty, shall be construed as an admission of any fault or liability whatsoever to the patient, doctor, health care professional, or to any third party. Medtronic makes no representation with respect to any potential impact of reimbursements on a **patient's eligibility to participate in a Health Savings Account or other tax**-favored health plan; please consult with a tax advisor as necessary. All rights reserved.