**THE PROCTER & GAMBLE COMPANY**

**AUTHORIZATION FOR USE AND DISCLOSURE**

**OF PROTECTED HEALTH INFORMATION**

**This authorization affects your rights to the privacy of your protected health information ("PHI")**. **Please read it carefully before signing.**

The Procter & Gamble Company and its subsidiaries (collectively, the "Company") sponsor certain self-insured group health plans in the United States (collectively, the "Plan"). The Plan will not limit eligibility or enrollment in the Plan or payment or reimbursement for healthcare services on your providing authorization for the requested use or disclosure.

By signing this authorization you acknowledge and agree that:

_____

*[Name or specific identification of person(s) or class of person(s), including business associates, authorized to make the requested use or disclosure. This means the person or business who will be disclosing the information]*

may use or disclose the following information:

_____

*[Identify the specific type of information to be used or disclosed.]*

for the purpose(s) of:

_____

*[Include a description of each intended use or disclosure. If the individual to whom the information pertains initiates the authorization, "at the request of the individual" may be used.]*

By signing this authorization you agree that:

_____

*[Name of authorized person or entity. This means the person or business who will be disclosing the information.]*

may disclose your PHI to:

_____

*[Name or other specific information of person(s) or entity to receive the requested use or disclosure.]*

Further, by signing this authorization you acknowledge that you have been provided a copy of and have received the Plan's HIPAA Notice of Privacy Practices containing a complete description of your rights, and the permitted uses and disclosures under HIPAA.

You have the right to revoke this authorization, in writing, at any time, except to the extent that the Plan has taken action in reliance on it or, if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy. A revocation is effective upon receipt by the Plan of a written request to revoke and a copy of the executed authorization form to be revoked at the following address:

Band III Director, Health & Wellness NA My P&G Services & US Benefits Delivery
**2 P&G Plaza GO TE3 Cincinnati OH 45201**

If related to South Boston On-Site Medical Plan: to the Band III Director Boston Site Medical Leader

OSMP Manager, South Boston Medical Plan, The Gillette Company, One Gillette Park, Mail Stop 1Y9 South Boston, MA 02127

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization; (b) a finding by the Secretary of the U.S. Department of Health and Human Services that this authorization is not in compliance with requirements of HIPAA; (c) complete satisfaction of the purpose(s) for which this authorization was originally obtained, to be determined in the reasonable discretion of the Plan; or (d) six (6) years from the date this authorization is executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Please keep a copy of this signed authorization when you submit it to the Plan.

Acknowledged and agreed to by:

_____ _____
Your Name Date

[OR]

On behalf of _____
(*Participant or Beneficiary if you are authorized to agree for someone else such as your minor child*)

By: _____ _____
Your Name (as Representative of the person listed above) Date

As: _____
Capacity as Representative (how are you this person's authorized representative)

You should return this completed form to:

Band III Director, NA Health & Wellness, My P&G Services & US Benefits Delivery
2 P&G Plaza GO TE3 Cincinnati OH 45201

If related to South Boston On-Site Medical Plan: to the Band III Director Boston Site Medical Leader

OSMP Manager, South Boston Medical Plan, The Gillette Company, One Gillette Park, Mail Stop 1Y9 South Boston, MA 02127

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, *et seq.*, and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").