



## Authorized Individual(s) Form

- This form can be used for patients who did not include authorized individuals on the enrollment application.
- Please return this form along with any additional documentation by mail or fax to:

**GSK Patient Assistance Program**  
**PO Box 220590**  
**Charlotte, NC 28222-0590**  
**Fax Number: 1-855-474-3063**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient ID:** \_\_\_\_\_

### Authorized Individuals

For the patient: If you would like to give permission to GSK for other individuals (i.e., an adult child, parent, friend) to conduct business on your behalf, please print their names here. Please note: These individuals are in addition to a legal guardian or registered advocate who may already be included on this application. For information about how GSK handles your information, please see our privacy notice at <https://privacy.gsk.com/en-us>.

<b>First Name</b>	<b>Last Name</b>	<b>Relationship to patient</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_