

Patient Authorization to Use/Disclose Health Information

I hereby authorize my physicians, pharmacists (including those specialty pharmacies that receive my prescription for Increlex™), and other providers (together, “Providers”), and each of my health insurers (together, “Insurers”) to disclose my health information, including but not limited to information related to my medical condition and treatment (including prescription information) and my health insurance coverage, to Tercica, Inc. and its representatives (“Tercica”), for the purposes described below.

Specifically, Tercica is authorized to receive, use, and disclose my health information in order to enroll me in the TerciCare Program, and, upon enrollment, to provide me with educational materials, information, and services related to Increlex™. Such services may include verifying and/or investigating my coverage for Increlex™ with my Insurers, who may disclose information about me and my coverage to Tercica. In addition, Tercica may use my health information to conduct market analyses, including aggregating my health information with other data for such analyses, and may further use and disclose my health information as required by law. Once my health information has been disclosed to Tercica, I understand that the federal privacy laws may no longer protect the information.

I understand that I may refuse to sign this Authorization. If I do not sign, my treatment (including the receipt of Increlex™), payment for treatment, insurance enrollment, or eligibility for insurance benefits, will not be affected, but I will not be eligible for enrollment in the TerciCare Program. I understand that I am entitled to a copy of this Authorization.

I may revoke (cancel) this Authorization at any time by mailing a letter requesting such revocation to: TerciCare c/o Tercica, 2000 Sierra Point Parkway, Suite 400, Brisbane CA 94005. Canceling this Authorization will stop my Providers and Insurers from making further disclosures of my health information to Tercica, as described above, after the date that my letter is received and processed by them. However, revoking this Authorization will not affect Tercica’s ability to use and disclose information that it has already received.

This Authorization expires December 31, 2010

Signature of Patient or Legal Representative

Date

Print Name of Patient or Legal Representative Legal Representative’s Relationship to Patient