Patient Authorization Form

AstraZeneca medicine: _____

Patient Information

First Name: _____ Last Name: _____ DOB: ___/___/___

Street: _____ City: _____

State: _____ ZIP: _____ Home Phone #: _____ Mobile Phone #: _____

Email: _____

I authorize my health care providers (HCPs) and staff, my health plan, and my pharmacies to use and share Protected Health Information (my "Information") with AstraZeneca (including Access 360) and its affiliates, as well as its contractors ("AstraZeneca"). My Information includes my prescription-related health records, Information about my health care plan benefits, demographic, contact, and any other Information bearing on my health. My Information may be used to verify treatment and payment decisions with my HCPs; investigate and assist with coordination of coverage for AstraZeneca products; coordinate prescription fulfillment and financial assistance; and perform internal analysis at AstraZeneca to better meet patient needs. I understand and agree that AstraZeneca may contact me by mail, email, and telephone. I understand that federal privacy laws may not protect my Information once it is disclosed; however, AstraZeneca agrees to protect my Information by using and disclosing it only for purposes specified. I understand that I can refuse to sign this Authorization and that this will not affect my treatment or payment for treatment, insurance coverage, or eligibility for benefits. However, if I do not sign this Authorization, I will not be able to receive Access 360 support. I understand that I may cancel this Authorization at any time by calling 1-844-ASK-A360 or by mailing a letter requesting such cancellation to One MedImmune Way, Gaithersburg, MD 20878. I understand that any such cancellation will not apply to any Information already used or disclosed based on this Authorization prior to their receipt of the cancellation. This authorization expires two (2) years from the date signed below, unless a shorter period is required by state law.

Which best describes you? ☐ I am a patient ☐ I am a legally authorized representative Relationship to patient: _____

Communication Preference: ☐ Email ☐ Text ☐ Both*

(I understand that AstraZeneca can send me text messages generated by an automated dialer if I provide my mobile number and that text messaging rates may apply. I also understand that consent is not required to make a purchase.)

Not Required

Print Patient Name/Legally Authorized Representative Name

_____

Signature of Patient/Legally Authorized Representative

SIGN HERE _____ **Date:** ___/___/___

Optional Enrollment To Receive Additional Information About My Condition

I understand that I may also receive ongoing information and support related to my condition, including treatment information. This may include AstraZeneca or a third party working on AstraZeneca's behalf contacting me by telephone regarding AstraZeneca support programs that may be of interest to me. Information provided by AstraZeneca does not take the place of talking to your health care provider about your treatment or condition. AstraZeneca or third parties working on its behalf will not sell or rent your personal information. If, in the future, you no longer want to receive these materials or calls, or you want to report a medication side effect, please call 1-800-236-9933. Please visit www.azprivacynotice.com to review our Privacy Notice.

☐ Yes, I would like additional information

Communication Preference: ☐ Email ☐ Text ☐ Both*

(I understand that AstraZeneca can send me text messages generated by an automated dialer if I provide my mobile number and that text messaging rates may apply. I also understand that consent is not required to make a purchase.)

Not Required

Once completed and signed, fax this form to 1-844-329-2360. You may need to provide additional information depending on the type of support requested.

1-844-ASK-A360 (1-844-275-2360) **1-844-FAX-A360** (1-844-329-2360) **www.MyAccess360.com**

Access360@AstraZeneca.com **One MedImmune Way,** Gaithersburg, MD 20878