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**Please review the PATIENT PRIVACY AUTHORIZATION below before signing.**

By signing below, I authorize each of my/my child's "Healthcare Providers" (eg, physicians, pharmacies, and other healthcare professionals and facilities and their staff) and "Insurers" (eg, my health insurance plan(s)) to share my/my child's protected health information, including information about my/my child's insurance, prescriptions, and medical condition ("My/my child's Information") with Ascendis Pharma Endocrinology, Inc. and its subsidiaries, affiliates, vendors, agents, and representatives (collectively "Ascendis") for the purposes described below. I also authorize my/my child's Healthcare Providers, Insurers, and Ascendis to use My/my child's Information and share it with each other for the purposes described below.

I understand that my/my child's Healthcare Providers, Insurers, and Ascendis will receive, use, and disclose My/my child's Information for the purposes of enrolling me in, and providing services through the Ascendis Signature Access Program (A·S·A·P) (the "Program"), including to: (1) process my/my child's request for enrollment in the Program, determine if I am eligible to participate in the Program, and provide the Services as applicable; (2) verify and assist with my/my child's coverage for the prescribed product indicated above with my/my child's Insurers; (3) evaluate, improve, or develop the Program's services and other internal business purposes; (4) facilitate and manage the Program; and (5) de-identify My/my child's Information and combine it with other de-identified data for purposes of research, education, business analytics, marketing studies, or for other commercial purposes.

Further, to the extent that I provide my/my child's consent for the optional Support Program Consents, I authorize my/my child's Healthcare Providers, Insurers, and Ascendis to use and disclose My/my child's Information for the purposes contemplated therein.

I understand that service providers for the Program may be paid by Ascendis for their services and data. This may include payment for sharing My/my child's Information and other data in connection with the Program, as allowed in this Authorization.

I understand that Ascendis will use reasonable efforts to keep My/my child's Information private, but once My/my child's Information is disclosed as allowed in this Authorization, it may no longer be protected by federal privacy laws. I understand that I am not required to sign this Authorization. My choice about whether to sign will not change how my/my child's Healthcare Providers or Insurers treat me. If I do not sign this Authorization, or cancel or remove my permission later, however, I understand I will not be able to participate in or receive assistance from the Program.

I understand I may request a copy of this Authorization. This Authorization will remain in effect for ten (10) years from the date of signature, except where state law requires a shorter time, or until I am no longer participating in the Program. Information collected before that date may continue to be used for the purposes set forth in this Authorization. I understand that I may cancel the permissions given by this Authorization at any time by informing Ascendis in writing by fax at 1-855-813-2039 or by mail at A·S·A·P, 1710 N Shelby Oaks Drive, Memphis, TN 38134. I can also cancel my permission by informing my/my child's Healthcare Providers and Insurers in writing that I do not want them to share any information with Ascendis. I further understand that if I cancel my permission, it will not affect how Ascendis uses and shares My/my child's Information received by Ascendis prior to my cancellation.

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**CONFIRMATION OF PATIENT CONSENT AND AUTHORIZATION (ALWAYS COMPLETE IF ENROLLING)**

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

**My signature below certifies that I have provided accurate and complete information and that I have read, understood, and agree to the PATIENT SUPPORT PROGRAM CONSENTS including any optional consents identified with a checked box.**

**By checking this box, I consent to the optional Text Messaging and Automated Communications as described above. I have provided my mobile number in the Patient Information section.**

**Required – Patient Signature (or Legal Representative<sup>†</sup>):**

\_\_\_\_\_ **Date:**

**My signature below certifies that I have read, understood, and agree to the release of my protected health information pursuant to the PATIENT PRIVACY AUTHORIZATION.**

**Required – Patient Signature (or Legal Representative<sup>†</sup>):**

\_\_\_\_\_ **Date:**

<sup>†</sup> Only representatives with legal authority for healthcare decisions may certify on a patient's behalf.