## Ascendis Pharma
## Patient Authorization Form

By signing below, I authorize my healthcare providers, pharmacies, and health insurance plan (collectively, my "Health Team") to share my contact and health information (personal health information, or "PHI") with Ascendis Pharma Endocrinology, Inc., its affiliates, and their respective vendors (collectively, "Ascendis") in connection with my participation in the Ascendis Signature Access Program® (A·S·A·P), as detailed below. I authorize Ascendis to communicate with my Health Team about me and use my PHI in order to: (1) assess my eligibility for the A·S·A·P, co-pay support, or free drug programs; (2) provide me with benefits verification and reimbursement support; (3) provide me with devices or starter kits where appropriate and disease management or other educational materials, and (4) help evaluate and improve Ascendis products, services, and operations. I also authorize my Health Team to give me information about Ascendis products and services, understanding that it may receive financial remuneration for doing so. I understand that once my PHI is shared pursuant to this authorization form, it may no longer be protected by applicable privacy laws and could be re-disclosed, but that Ascendis intends to use and share my PHI only for the purposes described in this form or as otherwise permitted by law. I understand that I do not have to sign this form in order to receive medical treatment or health insurance coverage. However, if I do not sign this form, A·S·A·P will not be able to provide me with any assistance.

I understand that this authorization will remain in effect for five (5) years (unless a shorter time period is required by applicable law), unless I notify both my healthcare provider and Ascendis (by fax to 1-888-436-0193 or by mail to PO Box 1587, Jeffersonville, IN 47131) that I am revoking the authorization. I understand that if I revoke this authorization, that will not invalidate any use or disclosure of my PHI that took place before my notice of revocation was received by Ascendis. I understand I am entitled to receive a copy of this form after I have signed it below.

☐ By checking this box, I also consent to receive promotional or marketing communications from Ascendis and A·S·A·P. I understand that I can opt out of these communications at any time by contacting A·S·A·P at 1-844-442-7236.

| Signature of Patient or Patient Representative | Printed name of Signer | Date |
|---|---|---|
| Printed name of Patient | Relationship to Patient | Date |

If signed by patient representative, please indicate below the authority to act on behalf of the patient:

☐ Parent ☐ Legal Guardian ☐ Power of Attorney to make healthcare decisions

☐ Other: _____

For details about how we collect and use PHI, including applicable US privacy rights and notices under applicable state law, please visit https://ascendispharma.us/privacy-policy/.