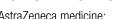
Patient Authorization Form





AstraZeneca i	medicine:
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Patient Information				
First Name:		Last Name:	DOB	B:/
Street:			City:	
State:	ZIP:	Home Phone #:	Mobile Phone #	† :
Email:				
Information (my "Information (my "Information (my "Information ("AstraZeneca"). My Information (my "Information contact, a payment decisions with prescription fulfillment AstraZeneca to better mand text. I understand tagrees to protect my Information and that the However, if I do not sign may cancel this Authorial AstraZeneca Access 36 apply to any Information authorization expires two	ation") with Astraz ormation includes r and any other Info my HCPs; investi and financial ass leet patient needs that federal privac ormation by using his will not affect r in this Authorization ization at any time of at One MedImm in already used or	es) and staff, my health plan, and deneca (including AstraZeneca Accomy prescription-related health recommation bearing on my health. My gate and assist with coordination istance; coordinate educational related and agree that Astracy laws may not protect my Informand disclosing it only for purposes my treatment or payment for treatment, I will not be able to receive Astrony, I will not be able to receive	ess 360) and its affiliate rds, Information about my Information may be used of coverage for AstraZectursing support; and periodical partial and the support of the property of the property of the periodical partial and the periodical partial and the periodical property of the property	es, as well as its contractors by health care plan benefits, sed to verify treatment and eneca products; coordinate erform internal analysis at by mail, email, telephone, sed; however, AstraZeneca that I can refuse to sign this ge, or eligibility for benefits. Support. I understand that I esting such cancellation to y such cancellation will not pt of the cancellation. This e law.
Which best describes you? Communication Preference:	I am a patient Email Text	I am a legally authorized representative Both	Relationship to patient:	
Print Patient Name/Legall				
Signature of Patient/Lega	lly Authorized Repre	esentative		

Optional Enrollment To Receive Additional Information About My Condition And To Receive Promotional Information

By providing consent, I understand that I may receive ongoing information and support related to my condition which includes, but is not limited to, providing me with educational and promotional materials, information, special offers, and services related to my medical condition or therapy, as well as for market research purposes which includes contacting me to participate in focus groups, surveys or interviews. This may include AstraZeneca or a third party working on AstraZeneca's behalf contacting me by mail, telephone, email and/or text message regarding AstraZeneca support programs that may be of interest to me. I consent to receive marketing and non-marketing calls and texts from and on behalf of AstraZeneca, made with an auto-dialer or prerecorded voice, at the phone number(s) provided. Message and data rates may apply. My Information may also be used to perform internal analysis at AstraZeneca. I understand that I can refuse to provide this Authorization and that this will not affect my treatment or payment for treatment, insurance coverage, or eligibility for benefits. I understand that my consent is not required or a condition of purchase. I understand that I may cancel this Authorization at any time by calling 1-800-236-9933 or by mailing a letter requesting such cancellation to AstraZeneca Access 360 at One MedImmune Way, Gaithersburg, MD 20878, Information provided by AstraZeneca does not take the place of talking to your health care provider about your treatment or condition. AstraZeneca will not knowingly collect, use, or disclose personally identifiable information from a minor under the age of 18, If you are under the age of 18, please have your parent. quardian, or healthcare provider request the information on your behalf. Please visit www.globalprivacy.astrazeneca.com to review our Privacy Notice.

Yes, I would like additional information

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.



SIGN HERE

-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

