Patient Consent Form

Form can also be accessed online at www.albireoassist.com

Return completed form by fax: 866-853-0479
or email: help@albireoassist.com

HIPAA Authorization for Uses and Disclosures of Protected Health Information and Consent for Enrollment

1. **Authorization of Uses and Disclosures.** I hereby authorize and direct (1) all of the health care providers and pharmacies involved in my care and treatment, as well as their employees, office staff, and agents including affiliated health care practitioners (collectively "Providers"), and (2) health care plans and insurers (collectively "Insurers") to use and disclose my "protected health information" ("Information"), as described below, to Albireo Pharma, Inc. and its representatives and contractors (collectively, "Albireo"). I also expressly authorize all the uses and disclosures described herein where the Information is provided to Albireo by me.

2. **Description of Information.** I understand that my Information includes, but is not limited to, my name, date of birth, and other personal information and identifiers (including my address), medical information and records, including information about my health condition and treatment, and financial information (including information about my insurance) as well as other personal information collected by Providers and/or Insurers about me or otherwise provided by me to Albireo.

   I understand that my pharmacy, health insurers and third-party vendors may receive remuneration (payment) from Albireo Pharma Inc. in exchange for disclosing my Personal Information to the Albireo Pharma Inc. and/or for providing me with support services for the purposes described above.

3. **Purposes.** I authorize and direct Providers and/or Insurers to use and disclose my Information to Albireo for the following purposes:

   a. Operating and administrating medication access programs, including, but not limited to Albireo Assist;
   b. Coordination of prescription fulfillment through pharmacies;
   c. Medication adherence and compliance programs;
   d. Soliciting my participation in patient outreach and advocacy programs; and/or
   e. Other purposes related to patient care and access or similar activities.

4. **Communication.** By signing below, I authorize the use of my Information for Albireo to contact me about my prescription and related activities.

5. **Expiration.** Unless revoked, this Authorization will remain in effect for 10 years (or such sooner date as state law may require).

6. **Revocation.** I understand that I have the right to revoke this Authorization by requesting this in writing to Albireo at 10 Post Office Square (Attn: Patient Support), Suite 1000, Boston, MA 02109, however, I understand that such revocation will not be effective with respect to Information that has already been used and/or disclosed per this Authorization.

7. **Treatment not Conditioned; Signing is Voluntary.** I understand that Providers, Insurers, and/or Albireo will not condition my treatment on signing this Authorization. I can choose not to sign this Authorization. However, if I choose not to sign, Albireo will not be able to help me with the various access programs and other activities outlined above in Section 3.

8. **Potential for Redisclosure.** I understand that Information disclosed pursuant to this Authorization may be redisclosed by Albireo and may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA"), a federal privacy law.

9. **Copy.** I understand that I will be provided with a copy of this signed Authorization by Albireo, upon request.

Patient Name *(please print)*

Patient Authorization *(Please complete both sections)*

❑ If I check this box, I also authorize the use of my information for Albireo marketing activities and consent to receive marketing and promotional communications from Albireo, including information about opportunities to participate in market research.

By signing below I am consenting to the use of my Protected Health Information as described above.

Patient/Parent or Guardian Name *(if patient under 18 years of age) (please print)*	Additional Parent or Guardian Name *(if patient under 18 years of age) (please print)*
Signature of Patient / /	Signature of Parent/Guardian / /
Patient/Parent/Guardian/Personal Representative Signature Date	Additional Parent/Guardian/Personal Representative Signature Date
Description of Relationship to Patient	Description of Relationship to Patient

By signing below I am enrolling in Albireo Assist. I hereby give consent to Albireo, its affiliates and agents to send communications to me via the contact information I have provided to Albireo, including postal address, email address and telephone number (for purposes of voice calls and/or SMS text messages). I understand that this consent will be in effect until I cancel such request. I hereby certify that I have read the foregoing and fully understand the contents.

Patient/Parent or Guardian Name *(if patient under 18 years of age) (please print)*	Additional Parent or Guardian Name *(if patient under 18 years of age) (please print)*
Signature of Patient / /	Signature of Parent/Guardian / /
Patient/Parent/Guardian/Personal Representative Signature Date	Additional Parent/Guardian/Personal Representative Signature Date
Description of Relationship to Patient	Description of Relationship to Patient