BIOMARIN®

Authorization for Use and Disclosure of Protected Health Information by BioMarin

By signing this authorization, I agree to allow BioMarin Pharmaceutical Inc. and its agents, contractors, and assignees (collectively "BioMarin") to use and disclose my protected health information (PHI), including medical records, and financial and insurance coverage information, in order to:

- enroll me in, and contact me about, BioMarin Patient and Physician Support (BPPS)
- provide case management, including supporting my treatment, such as through telephone or electronic communications to assist with adherence to my medication regimen
- work with my insurance carrier and other potential funding sources to try to help me get coverage, reimbursement, or payment for BioMarin products

In addition, **by checking the boxes below**, I hereby authorize BioMarin to use and disclose my PHI in order to:

☐ provide me education and information relating to my treatment

☐ organize additional services to help support my treatment, e.g., through healthcare and social services providers

☐ conduct market research relating to my treatment, such as through patient surveys

I understand that I do not have to sign this Authorization. If I do not sign, however, I will not be eligible to receive services from BioMarin. I further understand that I do not have to check any of the boxes above. If I choose not to check the boxes, I understand that BioMarin will not be able to provide me with the related services. However, even if I do not check any of the boxes, I am still eligible to receive BPPS services, as long as I sign this form.

I also understand that I may cancel this Authorization at any time by faxing a signed letter to BioMarin at the number listed below. Canceling this Authorization will mean that I can no longer receive services from BioMarin and will stop BioMarin from making further use and disclosures of my PHI in order to provide services. However, even after I cancel this Authorization, BioMarin may still use and disclose my PHI as required by law or as necessary to ensure the quality and integrity of the services provided by BPPS.

This Authorization will expire 10 years after the date that I sign this form. I understand that I will receive a copy of this signed Authorization upon request from BioMarin Pharmaceutical Inc.

BioMarin Authorization

I have read and understand the terms of this Authorization. By signing this form, I knowingly and voluntarily authorize the use and disclosure of my PHI as described above. I understand that BioMarin does not in any way promise that it can find ways to pay for medically necessary products and services, and I know that I may have to pay for the costs of my care. I agree that a copy of this form may be treated as a signed original.

_____
Patient/Authorized Representative Signature

_____
Print Patient's Name

_____
Print Authorized Representative's Name (if applicable)

_____
Patient/Authorized Representative Address

_____
City, State, Zip Code

_____
Patient/Authorized Representative Telephone Number

_____
Best Time/Way to Contact Patient

_____
Date

_____
Patient Date of Birth

_____
Relationship to Patient

_____
Patient/Authorized Representative E-mail Address

Please fax completed form to **1-888-863-3361.** Provide a copy of this form to the patient and place the original in the patient's medical record.

BIOMARIN®

Authorization for Disclosure of Protected Health Information by Healthcare Providers and Health Insurers

This Authorization allows my healthcare providers, health plans, and health insurers to disclose my protected health information (PHI), including medical records, and financial and insurance coverage information, to BioMarin Pharmaceutical Inc. and its agents, contractors, and assignees (collectively "BioMarin"), for the purposes described below.

Specifically, by signing this Authorization, I authorize my healthcare providers, health plans, and health insurers to disclose such of my PHI (for example, my name, address, policy number, and dates of treatment) as BioMarin may request in order to:

- enroll me in, and contact me about, BioMarin Patient and Physician Support (BPPS)
- provide case management
- work with my insurance carrier and other potential funding sources to try to help me get coverage, reimbursement, or payment for BioMarin products

BioMarin may also further use and disclose my PHI as required or permitted by law, or as I may authorize. I understand that, once my PHI has been disclosed to BioMarin, federal privacy laws may no longer protect the information.

I understand that I do not have to sign this Authorization. If I do not sign, my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits, will not be directly affected. However, if I do not sign, I will not be eligible to receive services from BioMarin.

I also understand that I may cancel this Authorization at any time by faxing a signed letter to BioMarin at the number listed below. Canceling this Authorization will stop my healthcare providers and health insurers from making further disclosures of my PHI to BioMarin, as described above, after the date that my letter is received and processed. However, canceling this Authorization will not affect BioMarin's ability to use and disclose PHI that it has already received (unless the laws of my state prohibit BioMarin from continuing to use or disclose such PHI).

This Authorization will expire 10 years after the date that I sign this form. I understand that I will receive a copy of this signed Authorization upon request from BioMarin Pharmaceutical Inc.

Provider Authorization

I have read and understand the terms of this Authorization. By signing this form, I knowingly and voluntarily authorize the disclosure of my PHI as described above. I agree that a copy of this form may be treated as a signed original.

_____

Patient/Authorized Representative Signature

_____

Print Patient's Name

_____

Print Authorized Representative's Name (if applicable)

_____

Date

_____

Relationship to Patient

Please fax completed form to **1-888-863-3361.** Provide a copy of this form to the patient and place the original in the patient's medical record.