SPARK THERAPEUTICS
generation
PATIENT SERVICES℠

Authorization to Use and Disclose Health Information

In signing this form, I authorize my healthcare providers, insurers, health plans, and any of their vendors to provide Spark® Therapeutics, its affiliates, business partners, service providers, third-party contractors, and agents (collectively "Spark") with any and all of my genetic information, including my genetic test orders and test results, medical information, including my condition and diagnoses, insurance information, and demographic information ("My Health Information") that Spark requests for the purpose of providing patient support services to me and my family members.

I authorize Spark to use My Health Information for the following purposes:

- to contact me via mail, telephone, in electronic format or otherwise, to provide or offer information that it believes to be of interest to me
- to help verify and coordinate my insurance coverage (including whether I have government-provided health insurance), available benefits, and other financial assistance for which I might be eligible
- to review previous genetic testing results as part of confirming my eligibility for this product
- to provide logistical support such as facilitating appointments, travel, and lodging (where applicable) for the provision of services and products, including identifying appropriate treatment centers for me
- to help Spark develop programs and services that may be of interest to me or others with inherited retinal diseases (IRDs)
- to provide me with educational or marketing information about IRDs and their treatments
- for Spark's internal business purposes and analytics, including to analyze its patient population and evaluate and improve the patient support program

I understand that this Authorization is voluntary. If I decline to sign, I understand that Spark may be limited in the services that it would otherwise provide under its Spark Therapeutics Generation Patient Services℠ program, but my failure to sign this form will not otherwise affect my current and ongoing medical care, my ability to participate in Spark-sponsored programs in the future, or my eligibility for healthcare benefits. I understand that my healthcare providers, insurers, and health plans may receive remuneration (payment) from Spark in exchange for disclosing My Health Information to Spark.

Fax completed form to 1-678-727-1501 or email to mysparkgeneration@sparktx.com.

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I understand that I may revoke this Authorization at any time in writing by sending a letter to Spark at the following address listed: Spark Therapeutics / 3737 Market Street / Suite 1300 – Attn: Generation Patient Services / Philadelphia, PA 19104. Revoking this Authorization will prevent Spark from further using or disclosing my information, but will not affect uses and disclosures of my information that were already made in reliance on this Authorization.

I understand that once my information has been disclosed, federal privacy laws may no longer apply or protect the information from further disclosure. Unless I expressly revoke this Authorization, it shall remain in effect for five (5) years from the date I sign below. I may obtain a copy of this Authorization to keep for my records.

I agree to be contacted by Spark via mail, email, and telephone calls made by using an automatic telephone dialing system or pre-recorded voice at the number(s) and address(es) I have provided on this form for all marketing and non-marketing purposes described in this Authorization to Use and Disclose Health Information. I confirm I am the subscriber for the telephone number(s) provided and the authorized user for the email address(es) provided, and I agree to promptly notify Spark if any of the number(s) or address(es) change in the future. I understand that my wireless service provider's message and data rates may apply.

Name of patient (print)

Name of parent/guardian (print) (required if patient is under the age of 18)

Relationship to patient

Signature of patient or parent/legal guardian of patient (if patient is under the age of 18)

Date

Attestation of Government-funded Insurance (Medicare, Medicaid, CHIP, TRICARE) for purposes of determining my eligibility for certain financial assistance:

☐ I do have government insurance.

☐ I do not have government insurance.

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