PATIENT AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION AND MIRUM COMMUNICATIONS

P.O. Box 4487, St. Louis, MO 63006
Phone: 1-855-MRM-4YOU | 1-855-676-4968 | **Fax:** 1-855-282-4884 | Monday - Friday: 8:00 am - 8:00 pm ET

Please return completed form to P.O. Box 4487, St. Louis, MO 63006 or fax to 1-855-282-4884. You may also return this consent form to your doctor to fax on your behalf.

Authorization to Share Protected Health Information

By signing this authorization, I (or my representative) authorize my healthcare providers, health plans, and pharmacies (collectively, "Healthcare Organizations") to use and share my personal and health information related to my medical condition, treatment, and insurance coverage (my "health information") with Mirum Pharmaceuticals, Inc., its affiliates, agents, and representatives (collectively, "Mirum") (i) to contact me or my healthcare organizations, or others I have identified, about my disease or treatment, (ii) to work with my insurance carrier and other potential funding sources to try to help me get coverage, reimbursement, or payment for the medication ordered by my prescriber, (iii) for referral to and enrollment in patient support and/or financial assistance programs, (iv) to work with third parties to provide community resources and referrals, (v) for providing me with materials, information, and services related to my drug therapy and ways to help me maintain my prescribed treatment, (vi) for market research purposes, (vii) to improve, develop, and evaluate products, services, programs, or treatments related to my disease, (viii) to use aggregated de-identified data for research or publications, or (ix) as required or permitted by law. I understand that, once disclosed pursuant to this authorization, my health information may no longer be protected under federal or state law and could be disclosed to others, but I understand that Mirum will make reasonable efforts to keep it private and to disclose it only for the purposes set forth in this authorization. I understand that my pharmacy may be paid to share my information with Mirum as allowed under this authorization.

Mirum Communications

I authorize Mirum to contact me by mail, telephone (including voicemail), or email for education and marketing purposes, including contacting me for market research purposes about Mirum therapies or Mirum. I understand and agree that any information that I provide may be used by Mirum to help develop new products, services, and programs.

I agree and understand that my authorization is voluntary and that neither Mirum nor any of my healthcare providers, health plans, and pharmacies may condition my treatment, payment for treatment, enrollment or eligibility for benefits, including my eligibility to receive Mirum products, on whether I provide my authorization. However, if I do not provide authorization, I will not be able to receive the Mirum services and support described above. I understand that this authorization will remain valid for 10 years after the date set forth below or such earlier date as required by applicable law, unless I revoke it earlier by cancelling my enrollment in writing, which I may do at any time by contacting Mirum's representative at privacy@mirumpharma.com. I understand that my cancellation will not apply to any use or disclosure of my health information by my healthcare providers, health plans, or pharmacies before they receive notice of my cancellation. I understand I have a right to receive a copy of this authorization.

☐ By checking this box, I consent to receiving support, reminder, and educational text messages from Mirum to my mobile phone number. Standard text messaging rates will apply.

*Mobile phone _____

Print Patient or Authorized Patient Representative Name _____

Signature of Patient or Authorized Patient Representative _____

If Representative, Relationship to Patient:

☐ Parent/Legal Guardian ☐ Representative per Power of Attorney ☐ Spouse

Date _____