SareptAssist Learn & Connect Consent Form

A diagnosis of Duchenne muscular dystrophy (DMD) can lead to a lot of questions about what life with DMD might look like. Filling out this Learn & Connect Consent Form will allow our SareptAssist Team to help you get the answers you need.

You won't be required to start your loved one on a Sarepta therapy when you sign. Our SareptAssist team will simply be there to discuss resources and support with you.

Patient/Guardian Information

*Indicates Required Field

*First Name: *Last Name: Middle Initial:

Address: *City: *State: ZIP:

*Primary Contact: *Relationship to Patient:

*Primary Phone: Secondary Phone:

Best Time to Call: AM PM

Ok to Leave a Message? YES NO

Email Address:

Topics You Are Interested In:

DMD disease

Benefits and financial assistance

DMD educational resources

Patient/Guardian Authorization for SareptAssist Communication

*Patient/Guardian Name: *Patient Date of Birth:

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By signing below, I certify that I have or am the caregiver of someone living with Duchenne muscular dystrophy (DMD) who is amenable to either Exon 51, Exon 53, or Exon 45 skipping, is undergoing testing for DMD, or is someone in whom DMD is suspected.

I authorize Sarepta Therapeutics, its agents, including its commercial and field-based teams, and the SareptAssist Program (collectively "Sarepta") to discuss with me personal information about me, including information related to my medical condition, email address, and telephone number (collectively, my "PHI") for purposes of: (1) providing education and ongoing support services to me, (2) gathering feedback on my disease state, (3) contacting me by mail, email, phone, or fax for any of the above purposes, and (4) creating information that does not identify me personally for use for other legitimate purposes. I understand that once disclosed pursuant to this authorization, my PHI may no longer be protected under federal or state law and could be disclosed by Sarepta to others, but I also understand that Sarepta will make reasonable efforts to keep my PHI private and to disclose it only for purposes set forth in this authorization.

I understand that in order to receive the services described above, I must sign the authorization.

I understand that I may cancel my authorization at any time by contacting SareptAssist by fax at 1-800-621-5203, mail at 215 First Street, Cambridge, MA 02142, or email at SareptAssist@Sarepta.com. My cancellation of this authorization will be effective for Sarepta upon receipt, but the cancellation will not affect prior uses or disclosures of my PHI.

I understand that I have a right to receive a copy of this authorization.

Printed Name of Patient or Personal Representative: Date:

Patient, Parent, or Legal Guardian Signature: Date:

If signed by personal representative, state relationship to patient:

Please contact us with any questions at: SareptAssist, 215 First Street, Cambridge, MA 02142
Phone: 1-888-SAREPTA (1-888-727-3782)
Case Managers are available Monday-Friday 8:30AM-6:30PM ET.
Spanish-speaking Case Managers and interpreters for other languages are available.
FAX: 1-800-621-5203
Email: SareptAssist@Sarepta.com

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