AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

TITLE:	**"**ImmuneRACE" – Immune Response Action to COVID-19 Events
PROTOCOL NO.:	ADAP-006 WIRB® Protocol #20200625
SPONSOR:	Adaptive Biotechnologies Corporation
INVESTIGATOR:	Jennifer Dines, MD Adaptive Biotechnologies 1551 Eastlake Ave E Suite 200 Seattle, Washington 98102 United States
STUDY-RELATED PHONE NUMBER(S) AND EMAIL(S):	ImmuneRACE Toll Free Study Line (M-F 9 am – 8pm EST) (855)-419-3387 Study Doctor (206) 279-2486 Study Coordinator (206) 693-2032 Secure Fax Number (866) 623-4408 Secure Email clinicalservices@adaptivebiotech.com

I hereby authorize my health care providers, including my doctors, nurses, and any others who provide or have provided me with health care services, to disclose all of my medical records in their possession to Adaptive Biotechnologies Corporation and any persons or companies that are working for or with Adaptive Biotechnologies, or owned by Adaptive Biotechnologies (collectively, "Adaptive"), for Adaptive's use in conducting ImmuneRACE – Immune Response Action to COVID-19 Events, of which Adaptive is the sponsor (the "Study"). I authorize Adaptive to further share my medical records with Western Institutional Review Board® (WIRB®) for purposes of WIRB's review of the Study. I understand that, once my medical records are so disclosed, their confidentiality may no longer be protected under federal privacy law and the personal health information they

contain could be re-disclosed to others. I also understand, however, that Adaptive and WIRB do not intend to use or disclose my personal health information other than for purposes of the Study.

I am aware that I am not required to sign this authorization in order to receive treatment from my health care providers or to be enrolled in a health plan or be eligible for health plan benefits, but that I cannot participate in the Study unless I do sign this authorization.

I understand that I may revoke this authorization at any time by providing written notice to: Jennifer Dines, MD, Adaptive Biotechnologies, 1551 Eastlake Ave E, Suite 200, Seattle, Washington 98102. I also understand that any such revocation will not invalidate uses and disclosures of my medical records that are made in reliance on the authorization before the revocation is received by Adaptive. Unless and until I do revoke the authorization, this permission will be good until December 31, 2070.

I have read this document or had its contents explained to me, and I freely give my consent as described above. I understand that I will receive a copy of this document once it has been signed below.

Name of Patient	Signature	Date
Name of legal representative Authorized as legal guardian or other to act on behalf of patient	Signature	Date