Patient Consent Form

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is completely voluntary and that my Health Care Provider, _____ may not condition treatment on whether I sign this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ DOB: _____

1) I hereby authorize my Health Care Provider named above to release/disclose to: Kerecis, 2300 Clarendon Blvd., Ste 1210, Arlington, VA, 22201, USA.
2) The following medical information for treatment with Kerecis Products:

   A brief medical history and wound treatment information, including digital photographs of my skin wounds that are taken at one or more timepoint(s) during the course of my treatment with Kerecis Omega3 Wound, Burn or OR Products. The photographs may be taken by my healthcare provider. Any protected health information under the Health Insurance Portability and Accountability Act (HIPAA) will not be disclosed to Kerecis.

3) I understand and authorize that my medical information may be used for the following purpose(s):

   Kerecis may use the medical information related to the treatment of my wounds for educational or marketing/promotional purposes (e.g., display in product brochures, print advertisements, and internet presentations). Kerecis will have total ownership of any photographs and the right to edit, distribute, and use the photographs in any medium, the right to copyright and license the photographs.

   I permit my medical information as described above to be used without my additional consent.

4) This authorization may be revoked at any time by notifying my Health Care Provider named above in writing at _____. If I revoke this authorization, I understand that it will not have any effect on actions my Health Care Provider named above took before it received the revocation. I understand that any health information disclosed pursuant to this authorization to an individual or entity that is not covered by the state and federal privacy laws and regulations may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I expressly acknowledge that my Health Care Provider named above is not receiving remuneration, direct or indirect, for the use or disclosure of the health information covered by this Authorization.

_____ _____
Signature of patient or patient's representative Date

Print name of patient's representative: _____

Relationship to the patient: _____

_____ _____
Witness Date

THE ORIGINAL SIGNED COPY OF THIS AUTHORIZATION MUST BE KEPT WITH THE PATIENT'S MEDICAL RECORDS AND A PHOTOCOPY MUST BE PROVIDED TO THE PATIENT OR THE PATIENT'S REPRESENTATIVE
DO *NOT* SEND A COPY OF THIS AUTHORIZATION TO KERECIS