**PATIENT INFORMED CONSENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Name of Patient], hereby agree to have my personal health information, such as digitized photographs, clinical information, family history information and genetic information to be recorded, processed and stored, using a computer software accessible securely only by the examining physician and clinical team such as Face2Gene.

Face2Gene is a suite of phenotyping apps that facilitate comprehensive and precise genetic evaluations. Its core technology helps detect phenotypic traits to support clinical evaluations and enhance the interpretation of molecular diagnostic tests. The de-identified data (*i.e.*, data that cannot identify the patient in any way) is used for continued development and improvement of the technology behind Face2Gene and for scientific research advancements and discoveries.

Face2Gene is fully compliant with (i) US HIPAA regulations; (ii) EU GDPR and other EU personal data protection laws; as well as (iii) other privacy laws around the world. Any personal health information uploaded to Face2Gene is accessible only to the examining physician and his/her clinical team, unless you also agree to one of the following options:

Information, including digitized photographs, may be also shared with a group of expert healthcare professionals for professional commentary and consultation for clinical purposes. An example is posting a case to the Face2Gene Online Unknown Forum or sharing a photo with other healthcare professionals with undiagnosed patients with similar facies.

Information, including digitized photographs, may be also shared with all users of Face2Gene for informational and educational purposes. An example is including the photo in the Face2Gene Academy, the London Medical Databases, or a publication in a scientific journal or conference.

Other than indicated above, personal health information of patients will not be shared or published and you have the right to request no further usage of these data by contacting the following individuals:

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Name of examining physician]
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Email of examining physician]
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Address of examining physician]

By signing below, I understand that:

1. This authorization is voluntary and I am not required to sign it as a condition of treatment or participation in the evaluation.

2. I understand that this authorization will be provided to the examining physician and clinical team.

3. If I want to revoke this authorization or if I want my personal health information to be reviewed, updated, amended or removed from the relevant records, I can review, update, amend and delete information by requesting this directly to my examining physician and clinical team.

4. Once my personal health information is shared with the recipients listed above, Face2Gene may disclose my personal health information as described and that such disclosures may no longer be subject to certain federal privacy laws. Neither Face2Gene nor the examining physician/clinical team will share or sell my personal health information without my written authorization.

5. I acknowledge that I have already provided my written authorization for certain uses and disclosures of my personal health information in connection with my participation in the medical treatment / evaluation.

6. I acknowledge that this authorization, and any revocation of this authorization, are separate from and will not impact the authorization I provided as part of my participation in the Research Study described above.

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| Patient / Guardian's Signature | Date |
|  |  |
| Patient / Guardian’s Name | Patient / Guardian’s ID |
|  | |
| Relationship (if signed by guardian) | |