AUTHORIZATION AND RELEASE

1. Authorization and Release. This consent form authorizes the use and disclosure of my information by CAPTUREPROOF, Inc. ("CaptureProof").

2. The Application. CaptureProof offered an application using electronic data capture services that I used to track the progress of my CMT or as normalized data capture and to communicate with Hereditary Neuropathy Foundation ("HNF") and others (hereafter the "Application").

3. Description of Information. I utilized the Application to take and share photographs, videos, and survey answers and to send and receive messages that may contain my name, image or likeness as well as information about my CMT, related medical conditions and other personal information (my "Information").

4. Purposes. This authorization is being sought as part of a clinical trial in coordination with HNF to allow CaptureProof to disclose my Information to third parties for the purposes specifically described below, each of which I can agree to allow or I can disagree and not allow. I understand that I am participating in a data collection to be used in a prospective and retrospective clinical trial, study, or research.

5. Expiration. This Authorization and Release shall expire 5 years from the date of signature.

6. Revocation. I have the right to request in writing that this Authorization and Release be cancelled by sending an email to CaptureProof at: legal@captureproof.com and to HNF at: registrycoordinator@hnf-cure.org. I understand that such cancellation will not be effective with respect to my Information that has already been used and/or disclosed pursuant to this Authorization and Release.

7. Signing is Voluntary. I am voluntarily signing this Authorization and Release of my own free will.

8. Copy. I have the right to receive a copy of this Authorization and Release upon request to registrycoordinator@hnf-cure.org.

Authorization and Release

I understand that by my electronic signature below, I can agree to authorize CaptureProof to disclose my Information for any, all or none of the purposes mentioned here.

CaptureProof may disclose my Information, including my survey answers, photos or videos, to HNF for research, commercial and educational uses.
(__) I agree.
(__) I disagree.

By my electronic signature below, which I understand will be electronically date stamped, I have agreed to authorize CaptureProof to disclose my Information only for those purposes which I have agreed to above.

Patient Full Name: _____
Electronic Signature: _____
Relationship to Patient _____