PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION

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For use when authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

PRINTED NAME OF PATIENT _____ DATE OF BIRTH _____

I. MY AUTHORIZATION

I authorize the following using or disclosing party: _____

To use or disclose the following health information: (check those that apply)

- ☐ All of my health information
- ☐ My health information relating to the following treatment or condition: _____
- ☐ My health information covering the period from: _____ (date) to _____ (date)
- ☐ Other: _____

The above party may disclose this health information to the following recipient:

Name and Title: _____ at MoonRise Therapeutics, Inc.

Address: PO Box 90, Taftsville, VT 05073 Phone: _____ Email: _____

The purpose of this authorization is: (check those that apply)

- ☐ At my request
- ☐ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
- ☐ Other: _____

This authorization ends: (check one)

- ☐ On date: _____
- ☐ When the following event occurs: _____

II. MY RIGHTS

I understand that I have the right to revoke this authorization, in writing to the appropriate party, at any time, except where uses or disclosures have already been made based upon my original permission. I underatnd that uses and diclosures already made based upon my original permission cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization and that I may have the right to refuse to signn this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

SIGNATURE _____ PRINTED NAME _____

Guardian if under 18 *Guardian if under 18*

If requested please send records to: MoonRise Therapeutics, PO Box 90, Taftsville, VT 05073