VMP, llc
Expanding Genetic Horizons

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PATIENT-TEACHER CONSENT

I have been informed about the VMP Patient Teacher Registry and consent to presenting my firsthand experience with the metabolic disease that I have or that runs in my family. My participation can take many forms, including speaking to a medical audience, such as in a medical school or medical center.

I agree to have VMP retain the following personal information in a Registry:

> Name, address, phone number(s), email addresses, the diagnosis in me or my family, symptoms and other pertinent details useful for educational purposes

I understand that the public face of the Registry will only list my diagnosis and location (city, region); no other personal or identifying information will be revealed. No personal or identifying information about me will be released to any outside party, or organization, or company.

I understand that VMP may receive a request from an outside party for me to speak at their event. VMP may notify me of the request and who is making the request. I will in turn inform VMP whether or not I am available to participate in that speaking opportunity. If I choose to participate, VMP will provide me with the contact information and I shall directly contact the party for further details. I acknowledge that arrangements, including but not limited to travel expenses or payments, with outside parties as a result of being listed in this registry are between me and the outside party. VMP is neither involved nor responsible for arrangements, agreements, or payments that I make with outside parties as a result of being listed in the Registry.

It is my responsibility to keep VMP informed of any changes to my contact information. I understand that VMP will not provide any compensation to me for either participating in the Registry or for any presentations that may result from the Registry. I may withdraw from participating in this project at any time by notifying VMP in writing or by email at info@vmpgenetics.com.

I have read this Consent, and I fully understand and accept all terms by signing below. My consent to the above and any or all associated assignments remains effective until I revoke it in email to patientteacherregistry@vmpgenetics.com

_____ _____

PLEASE PRINT - PROBAND NAME **DATE OF BIRTH**

_____

PLEASE PRINT –NAME OF PARENT/GUARDIAN OF PROBAND AND THE RELATIONSHIP TO PROBAND if so signing

_____ _____

SIGNATURE – PROBAND OR PARENT/GUARDIAN **DATE SIGNED**