PATIENT CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____(NAME OF PATIENT)

give permission to

_____(NAME OR GENERAL DESIGNATION OF MEDICAL PRACTICE MAKING DISCLOSURE)

to disclose to *eMoyo* or their representative the following information:

- Clinical Information
- Medical History
- Test results

The purpose of the disclosure authorised herein is to consent to *eMoyo* to securely store patient information remotely.

_____(Date)

_____(Print Name)

_____(Signature of Patient)

Parent, Guardian or Authorized Representative, if required

_____(Print Name)

_____(Signature of Parent, Guardian or Authorized Rep)