**CONSENT FORM**

**Authorization for Use/Disclosure of Information**

I voluntarily consent to authorize **Tally** to use or disclose my health information during the term of this Authorization

**Purpose**

I authorize the release of my health information at the request of the patient

**Information to be disclosed**

I authorize the release of the following health information:

*All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical conditions and any treatment received by me*

**Type of Research Intervention**

This research will involve a single injection in your arm as well as four follow-up visits to the clinic.

**Redisclosure**

I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

**Refusal to sign/right to revoke**

I understand that signing this form is voluntary. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation. The revocation will be effective immediately upon my health care provider’s receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Patient Signature:

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