PATIENT INFORMATION AND CONSENT FORM AND AUTHORIZATION TO USE AND DISCLOSE PERSONAL HEALTH INFORMATION FOR RESEARCH

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Purpose of the Patient Information and Consent Form

This Patient Information and Consent Form may contain words you do not understand. Please ask the doctor or the consenting staff to explain any words that you do not clearly understand.

The purpose of this form is to give you information about the collection of your health information, and, if signed, will give your permission to allow Dr. Jafri to use your health information within a publication. You should take part in this data collection, only if you want to do so. You may refuse to take part and your refusal will not change any care you receive now or in the future. You should not sign this form if you have any questions that have not been answered to your satisfaction.

Introduction

You are being asked to provide permission for your health information to be used in a publication within a medical journal. Your information will be de-identified. This means that any unique identifying information, such as your name, date of birth, address, medical record number, social security number, dates of service will be removed from this data collection prior to publication.

Risks and Discomforts

Since this is a data collection, there is a risk of loss of confidentiality. Other risks associated with participation in this data collection are the same risks that are currently associated with your care. These risks would be possible whether or not you choose to participate.

Possible Benefits

There is no direct medical benefit to you. The scientific use of your data may help researchers discover better ways to improve patient care in the future.

Alternate Procedures

The alternative to participating in this study is non-participation. Not participating in this data collection will not deprive you of your treatment.

Confidentiality and Release of Medical Records
We will protect information about you and your participation in this data collection to the best of our ability. When information about you is published, your name will not be given. However, your doctors and designated representatives may look at the medical records.

Costs
There is no additional cost for your participation.

Legal Rights
The above section does not restrict your right to seek legal assistance. You do not waive any legal rights by signing this Patient Information and Consent Form.

Voluntary Participation/Withdrawal from Study
Your participation in this data collection is strictly voluntary and your decision not to participate will not affect your future medical care with your doctor.

Contact for Questions
If you have any questions about your participation in this data collection, you should contact:

Investigator's name: Syed Faisal Jafri, MD
24-hour contact number: (816) 361-0055

Subject's Statement of Consent

This data collection has been explained to me along with the possible risks. I have been told that if I refuse to participate, my treatment will not be affected in any way. I have had an adequate chance to ask questions and I know I may ask questions at any time in the future. I have been told that I do not give up any of my legal rights by signing this form. I have been told that I will be given a copy of this signed and dated informed consent form.

I voluntarily agree to take part in this data collection.

Rosa Claiborn — Signature of Patient
7-10-15 — Date
Rosa Claiborn — Printed Name of Patient

I certify that the information provided was given in language that was understandable to the patient.

Signature of Person Obtaining Consent
7/10/2015 — Date
JENNIFER W. FEEBACK — Printed Name of Person Obtaining Consent

Signature of Investigator
7/15/15 — Date

HIPAA notice and information

Authorization to use and disclose personal health information for research

The United States government has issued a new privacy rule to protect the privacy rights of patients. This rule was issued under a law called the Health Insurance Portability and Accountability Act of 1996. (HIPAA) The Privacy Rule is designed to protect the confidentiality of your personal health information. The document that you are reading, called an "Authorization," describes your rights and explains how your health information will be used and disclosed (shared).

In working with the sponsor, doctor, Dr. Syed Faisal Jafri, will use and share personal health information about you. This is information about your health that also includes your name, address, telephone number or other facts that could identify the health information as yours. This includes information in your medical record and information created or collected during the study. This information may include your medical history, physical exam and laboratory results. The doctor will use this information about you to complete this research. In most cases, the doctor will use your initials and assign a code number to your information that is shared with the sponsor.

By signing this Authorization, you allow the doctor to use your personal health information. You also allow the doctor to share your personal health information with:

- The medical journal for publication purposes

Your personal health information may be further shared by the groups above. If shared by them, the information will no longer be covered by the Privacy Rule. However, these groups are committed to keeping your personal health confidential.

You have a right to see and get a copy of your records related to the study for as long as the doctor has this information.

This Authorization will not expire.

AUTHORIZATION

I authorize the release of my medical records and personal health information related to this data collection. I have been told that I will receive a signed and dated copy of this Authorization for my records.

Rosa Claiborn — Signature of Patient — 7-10-15 — Date

ROSA Claiborn — Printed Name of Patient

[signature] — Signature of person obtaining Authorization — 7/10/2015 — Date

JENNIFER W. FEEBACK — Printed name of person obtaining Authorization