6111 Jackson Rd., Suite 200
Ann Arbor, MI 48103
734-327-2946
Fax: 734-327-3715
axiobionics.com

PATIENT CASE STUDY RELEASE FORM

Patient Name (print) _____ Authorized Representative (print) _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Street Address _____

City _____ State _____ Zip Code _____

Country: ☐ United States

Country _____

Email _____ Phone _____

PERMISSION TO RELEASE INFORMATION INCLUDING PHOTOGRAPHS, VIDEOS, ELECTRONIC OR OTHER MEDIA

I give AxioBionics, LLC and agents acting on its behalf permission to use certain information about the above-mentioned patient for the purposes of education, public relations, marketing, and promotion of AxioBionics and its pain management and neuromuscular stimulation Wearable Therapy® Systems and TripleFlex™ Orthoses. This may include photographs, video, audio, testimony, name, medical case history and results/outcomes. The items may be used by AxioBionics and by the media indefinitely. I understand that I can revoke this permission at any time by contacting AxioBionics at 800-552-3539. However, I also understand that AxioBionics has no control over disclosures made before I revoke my permission.

I understand that the released items will be used in various advertising and educational ventures such as seminars, training materials, the AxioBionics website, social media sites, email correspondence, advertisements, printed promotional literature, shared with news media for publication and/or broadcast and/or distribution via other means to the general public. I release AxioBionics, its agents and employees from liability for any and all claims by me or any third party in connection with my participation. I acknowledge that since my participation is voluntary, I will receive no financial compensation. I further agree that my participation confers upon me no rights of ownership whatsoever and the items may be destroyed at any time.

I understand that I may refuse consent and that this decision will not affect the patient's care.

The following information may be released: *(please check all that you agree to)*

☐ Photos ☐ Video ☐ Audio ☐ Testimony ☐ First Name ☐ Last Name ☐ Case History

Patient or Authorized Representative (print) _____ Signature _____ Date _____

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PERMISSION TO USE CLINICAL DATA FROM YOUR MEDICAL CHART FOR RETROSPECTIVE ANALYSIS TO IMPROVE FUTURE CLINICAL CARE AND PRODUCT DESIGN

AxioBionics understands that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information (PHI) for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form. If you have any questions you may ask them now or at any time in the future.

In order to continually improve our devices and increase the number of patients we can help, AxioBionics is constantly monitoring our patients' health data and applying that data to further our understanding of our devices' safety and effectiveness. The information that will be collected during your treatment will be kept confidential. Data used for any studies will be kept anonymous. Any information that could potentially identify you as an individual will be protected and will not be shared with or given to anyone outside of AxioBionics.

I release AxioBionics, its agents and employees from liability for any and all claims by me or any third party in connection with my participation. I acknowledge that since my participation is voluntary, I will receive no financial compensation.

I understand that I may refuse consent to the use of my data and may revoke this permission at any time by contacting AxioBionics at 800-552-3539. However, I also understand that AxioBionics has no control over disclosures made before I revoke my permission. This decision will not affect the patient's care.

Patient or Authorized Representative (print)	Signature	Date

You have the right to receive a copy of this form after you have signed it.