



Voice: 404.793.7800  
Fax: 866.744.5665  
www.vmpgenetics.com

**PATIENT TEACHER REGISTRY CONSENT**

I have been informed about the VMP Genetics 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 Genetics 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 Genetics may receive a request from an outside party for me to speak at their event. VMP Genetics may notify me of the request and who is making the request. I will in turn inform VMP Genetics whether or not I am available to participate in that speaking opportunity. If I choose to participate, VMP Genetics 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 Genetics 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 Genetics informed of any changes to my contact information. I understand that VMP Genetics 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 Genetics in writing or by email.

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