PATIENTS: Please sign, date, and return with your sample.

Blueprint Genetics

MY RETINA TRACKER® REGISTRY
HIPAA AUTHORIZATION

I hereby authorize Blueprint Genetics Inc. and its affiliated companies ("Blueprint Genetics") to disclose my protected health information ("PHI") as described in this Authorization to the Foundation Fighting Blindness, which funds retinal disease research ("Foundation").

This Authorization applies to the following PHI:

- Any and all information in laboratory report(s) relating to my inherited retinal degenerative disease ("IRD") testing.
- Name, date of birth, contact information including phone numbers and email addresses, and other information provided on the requisition (including the My Retina Tracker Registry Self Evaluation Questionnaires).

I authorize Blueprint Genetics to disclose the PHI described above to the Foundation.

The Foundation provides the My Retina Tracker Registry, which is a research database of people affected by IRDs. The Registry provides de-identified information to IRD researchers and clinical communities. In particular, the Registry supports an understanding of how common each type of retinal disease is, how the disease progresses, and the genes that cause the disease as well as a general understanding of the impact of IRD. The Registry also helps researchers and companies find people who might be interested in participating in research studies and clinical trials. I authorize the release of my PHI as part of my participation in the My Retina Tracker Registry.

This Authorization becomes effective immediately upon my signature and shall continue until I revoke it. I may revoke this Authorization by providing written notice to Blueprint Genetics at support.us@blueprintgenetics.com.

I understand that:

- This Authorization is voluntary, and I may refuse to sign it. However, if I do not sign this Authorization, I will not be eligible to receive the My Retina Tracker genetic testing without cost to me.
- I may revoke this Authorization at any time by sending a written revocation notice to Blueprint Genetics. The revocation will not have any effect on any actions taken in reliance on this Authorization.
- Information used or disclosed pursuant to this Authorization will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) and may be subject to redisclosure by the Foundation.
- Blueprint Genetics receives financial compensation from the Foundation for your My Retina Tracker genetic testing and this Authorization.
- I have a right to a copy of this Authorization.

By signing this Authorization, I agree that I have read and understand it and authorize the disclosure of PHI as set forth in this Authorization.

SIGNATURE:	DATE:
PATIENT NAME:	PATIENT DOB:

Please sign and return this Authorization with your specimen, or fax to the number below.

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