PATIENT CONSENT (PART A)

The patient has received and agreed to the Patient Consent form. -I acknowledge my consent to take this test and that the information provided by me is true and that the specimen I am providing is my own. I also hereby authorize the testing laboratory to release medical information to me through the email address I am providing below. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law. -I acknowledge that a positive test result is an indication that I meet the criteria for self-isolation in an effort to avoid infecting others. I understand that testing does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care, and treatment from my medical provider regardless of my test results.

INFORMED CONSENT FROM PATIENT (PART B)

I consent PMCDx to process my sample according to the test that I have ordered. 1. My specimen has not been adulterated in any way. 2. I have the right to receive my own test results directly from the laboratory. 3. I authorize the laboratory to release the results to the requesting or ordering healthcare professional. 4. I authorized the laboratory to my insurance benefits to be paid directly to the laboratory. 5. I acknowledge that the laboratory may be out of network provider. 6. If I receive payment from my insurer, I will endorse the check and forward it to the laboratory 7. Or I may write a personal check of the full amount to the laboratory 8. If I select self pay or if self pay was selected for me, I acknowledge my financial responsibility for all laboratory charges in processing my specimen. 9. I understand that I may receive separate bills from the laboratory and from health care providers.As required by the State of Maryland (where PMCDx laboratory is located), a licensed healthcare professional is required to sign your test requisition to order the test. By signing this informed consent form, you are expressly authorizing PMCDx to provide a licensed healthcare professional to sign your test requisition form and to receive your test results. The healthcare professional may contact you as to the appropriateness of the test that you are ordering and may provide you with medical support of your test results as needed. Background The laboratory accepts your sample to test for the purposes of gathering information about your health status and to provide your health care professional with test results to aid in your personal health care and treatment. Your Sample The laboratory will process your sample for the tests requested by you or your health care professional and return those test results to your health care professional. Your sample may be retained by the laboratory as a matter of routine clinical operations according to the laws and regulatory requirements of your state. However, the laboratory may keep your leftover sample longer to perform research and development of new tests not yet determined if you elect to do so. The laboratory may transfer your leftover sample to another laboratory or research facility to conduct further analysis of your sample. You will not be further compensated for this use of your sample. You may withdraw your permission to use your leftover sample for additional research at any time by writing to us. If you withdraw your permission, we will not use your sample in any future research activities, but we cannot undo any processing that might have been done prior to your withdrawal from participation. Your Information To process your sample, the laboratory may gather your basic information such as your name, date of birth, your address and other contact information from you. There is a requirement by law for the laboratory to have certain information about your sample and you for some tests. The laboratory may have health data about your previous conditions, your prescriptions and your previous treatments to provide sufficient context for your test results. The laboratory may gather information about health outcomes of people who are related to you or your partner to establish how they may have impacted your health. If we find that you have had infections or cancer(s) we may add information from the appropriate registries. Information from Elsewhere he laboratory in its day to day work may gather the results of different types of tests performed in other laboratories. These tests result and other medical information may be stored in your electronic health records. There may be health information that describes medical procedures, images from X-rays, or it may contain previous conditions and how you were treated and whether that treatment was effective. To gather your information together in one place provides a better picture of who you are. To access these external records, you may authorize us to access your electronic health records and waive HIPAA restrictions so your information can be shared with us. A HIPAA Authorization Form is provided for you to fill out. This form will name the entity or health provider that has your Protected Health Information (PHI) and will allow them to share your health information with us (see form at the end of this Informed Consent Form). Your health provider may have its own form to authorize sharing of your information. You may choose to not to authorize and waive HIPAA to prevent us from sharing your test results with other healthcare professionals involved in your care at any time by writing to us. Permission to Contact You We would like to contact you if a research entity or sponsor requests your permission to participate in a research study or clinical trial. Each study will have specific risks which will be explained to you in full before proceeding. In addition to the essential information that the laboratory requires to process your sample, the laboratory may gather information that may not seem health related but may impact your health care. We may ask you directly for more information about how long or regions or conditions where you have lived and worked if the researchers think that there is a possibility that outside factors in your environment affected your health. This effect can be positive or negative on your health. We would like to contact you from time to time to keep your information current. We will contact you to confirm that your email, phone number(s) and your home address. We will ask you for a phone number or email address for a family member or a friend as a backup in case we need to reach you. We might use social media or public listings to help us contact you if we are not able to otherwise. You may withdraw your permission to allow us to contact you regarding participation and/or request for more information about a research study or clinical trial or requesting additional information at any time. How Your Information Will be Used? The laboratory has contracted a clinical information company to store your information securely and maintain your privacy accordingly. Your personal information that identifies you will be removed from your health information. Your de-identified, though may not be absolutely anonymous information will be stored in a database with information from other patients. Access to the database will be tightly controlled and will not be available to the public. Authorized researchers will access the database to use your de-identified information with thousands of other patients to learn more about our collective health. Researchers will study nearly any topic to learn about how things affect our health. It is unknown at this time what topics will be studied. Some examples of possible use include studies on why some people get a certain disease while others do not; or why some people get better on a drug while the same drug does not help others with the same condition; or how or why a disease occurs; or how to stay healthy longer; or used to develop better drugs. Researchers may use your test results and basic facts about you to learn about what things affect the health of people who are the same race, sex, ethnic or age group as you or live and/or work in the same place(s) as you. Some of the researchers may work for commercial companies like the drug companies or manufacturers of disease tests or medical instruments. Some researchers may work in university medical centers with teaching hospitals to train new doctors. You may withdraw your permission at any time to participate with other patients in studies using the combined database by writing to us. If you withdraw your permission, we will not use your information in any future research activities but cannot retrieve any information that has already been accessed by researchers. We will remove your information from the aggregated database, but we will keep your information as required by the regulations and laws. What Are My Risks for Taking Part in the Database? The main risk of taking part in the options above is to your privacy. If the database is breached someone may see your information without permission and misuse it. Even if the data are de-identified and anonymous, there is a chance that someone could figure out who you are. We believe that the chance of this happening is very small, but it is not zero. How Will My Information be Protected from Misuse? We and all business associates will take great care to protect your de-identified information. We are continually improving how we keep your data and your privacy secure and will keep up to date in the methods where we can monitor the security of your information. p We will limit who is allowed to see any information that is already de-identified so that they will not normally be given access to personal information that can identify you. In this level of access, our researchers must sign an agreement that they will not try to find out who you are. We will require another specific authorization before anyone can see the information that can identify you. Such authorization would be granted only if there might be a benefit to you. We will tell immediately if there has been a breach of our database or unauthorized access and what steps are taken to remediate or mitigate the situation. The database of information is encrypted from end to end and stored in a secure health cloud. The security is monitored continuously. The laboratory and the clinical information company has policies and practices in place to minimize the chances of unauthorized access. I have read this information completely and understand the testing service offered by PMCDx Laboratory. I have had the opportunity to ask questions regarding the service and this consent information and agree to receive the service provided. I have read this information completely and understand the testing service offered by PMCDx Laboratory. 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HIPAA AUTHORIZATION FORM

I, as the patient, hereby authorize the use and disclosure of my protected health information (PHI) as described below: 1. AUTHORIZED PERSONS OR COMPANIES TO USE AND DISCLOSE PROTECTED HEALTH INFORATION Authorized persons or companies are authorized to disclose and share the following protected information to the Laboratory and Ovation.io, Inc. 2 Union St Ste 301, Portland ME 04101. 2.DESCRIPTION OF INFORMATION TO BE DISCLOSED AND SHARED The health information that may be disclosed is: p Medical records p Communicable diseases (including AIDS and STDs) p Alcohol and other drug abuse treatment p Mental health records p All treatment records including drug prescriptions and surgical procedures All past, present and future periods of health care information may be shared. 3. PURPOSE OF THE USE AND DISCLOSURE The purpose of this disclosure and sharing is to provide comprehensive information about the patient: All medical information gathered in one place for each patient when combined and aggregated with similar information from other patients may provide insights in medical care that would not be possible otherwise 4.VALIDITY OF AUTHORIZATION FORM The authorization form is valid on the date of that this form is signed. 5. ACKNOWLEDGEMENT I understand that the information used or shared under this Authorization Form may be subject to re-disclosure by the person(s) or companies receiving it and would then no longer be protected by federal privacy regulations. I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke the authorization in writing at any time. I understand that my action already taken in release on this authorization cannot be reversed, and my revocation will not affect these actions.