Aurora Therapeutics, Inc.
Katherine Clements, N.D., L.M.T.

Client/Patient Testimonial Release Consent

Purpose of Consent: By signing this form, you are hereby consenting to allow Aurora Therapeutics, Inc. and Sarasota Healing Arts, Inc., and their employees, assignees, or agents, to use, reproduce, or distribute and disclose the information in your testimonial and acknowledge that your testimonial may be distributed to the public for purposes including but not limited to advertising and promotions, press coverage. I understand that I am not entitled to compensation for use of said testimonial (and/or photographic/videographic likeness) nor input concerning its use. I understand that any written information I provide may be edited. I am voluntarily providing the above mentioned and sharing my story.

Right to Revoke: You have the right to revoke this Release at any time by providing written notice of your revocation. Please understand that revocation of this Release will not affect any action Aurora Therapeutics, Inc. and Sarasota Healing Arts, Inc., and their employees, assignees, or agents took in reliance on this Release before receiving your revocation.

I hereby authorize Aurora Therapeutics, Inc. and Sarasota Healing Arts, Inc., and their employees, assignees, or agents and staff to use my testimonial (and/or photographic/videographic likeness) and any information contained herein in its public relations efforts. I understand and approve the disclosure of testimonial information to the media and other individuals and entities that may be involved in the public relations efforts of Aurora Therapeutics, Inc. and Sarasota Healing Arts, Inc., and their employees, assignees, or agents.

I understand that I am providing only the testimonial information (and/or photographic/videographic likeness) to Aurora Therapeutics, Inc. and Sarasota Healing Arts, Inc., and their employees, assignees, or agents and that my treating healthcare provider will not be providing any protected information to the media or the public, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release Aurora Therapeutics, Inc. and Sarasota Healing Arts, Inc., and their employees, assignees, or agents from any and all claims for damages of any kind based on the use of my testimonial or information in the testimonial (and/or photographic/videographic likeness). By signing below I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Consent to Release my Client/Patient Testimonial (and/or photographic/videographic likeness).

I ask that: (please check one)

- ○ I am identified by full name (Jane Doe, Sarasota, Fl.)
- ○ I am identified by first name and last initial only (Jane D., Sarasota, Fl.)
- ○ My identity remains anonymous (Anonymous, Sarasota, Fl.)

_____

Signature Date

_____

Print Name

_____

Address

_____ _____

Phone Email

2206 Jo An Drive suite 4 Sarasota, Florida 34231 ph: 941.951.6820 fax: 941.951.6821