INFORMED CONSENT AND MEDICAL RELEASE FORM

10X Health Ventures, LLC dba 10X Health System ("10X Health") and its network of healthcare providers and laboratories provide healthcare that may be nontraditional or unconventional. Such services and products are commonly referred to as complementary or alternative medicine, holistic, or innovative services. 10X Health services may include nutritional and herbal products and consultations, prescription medication, IV Therapies, supplementation, alternative approaches to health difficulties, and innovative laboratory testing (e.g., blood, genetic, gut, etc…) and diagnosis.

Some of the foregoing services may not be medically necessary or recognized as the standard of medical practice or care in your state or country. While long practiced, such services may be considered investigational or experimental by the conventional medical community. Certain 10X Health products or services may have their own consent forms and/or terms and conditions.

By signing below, accepting these terms electronically or electing to receive services and products from 10X Health, I, as the customer or parent/legal guardian of the customer ("I" "Me" or "Customer"), understand that I am voluntarily entering into this informed consent and medical release form ("Form"). I hereby expressly agree and consent to the following:

1. I consent to the release of my blood/genetic/gut/other lab results to 10X Health, the 10X health network of healthcare providers and laboratories, and any other person I authorize, to allow the provision and completion of the services and to allow the provider(s) to review my results and conduct a follow up consultation if I so choose.

2. I consent to allow 10X Health and its network of healthcare providers and laboratories to access my entire medical history, including my medication history.
3. I certify I am at least 18 years old.
4. I certify I have had the opportunity to read and consider the 10X Health System **Privacy Policy** and **Terms of Service** to my satisfaction prior to entering into this Form.
5. I accept that the 10x Health services, including counseling/explaining of results, may be rendered in a telehealth setting, a 10X Health clinic, concierge visit or via an independent laboratory (e.g. LabCorp).
6. I understand that, as with any medical procedure, there are potential risks and discomforts associated with 10X Health products and services. These may include:
    - Temporary pain or discomfort at the site of needle insertion
    - Bruising or swelling at the puncture site
    - Infection, although rare, at the puncture site
    - Fainting or dizziness during or after the test
    - Rarely customers may experience the following:
      Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury
    - Extremely Rarely customers may experience the following:
      Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death
7. I have been provided with an opportunity to ask questions about all 10X Health products and services, and my questions have been answered to my satisfaction. I understand that this consent is voluntary, and I have the right to refuse or withdraw consent at any time before or during the services.
8. REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing by emailing **privacy@10xhealthsystem.com** or by mail at: 10X Health System, 2920 NE 207th Street, Suite 901, Miami, FL 33180. I understand that the revocation will not apply to information that has already been released in response to this authorization.
9. This authorization will automatically expire one (1) year following the date of signature, except that this authorization will expire automatically after ninety (90) days if it pertains to my complete medical record.
10. I understand that the medications I am being prescribed are solely for me based on diagnoses derived from my submitted medical history, blood/genetic/gut/other lab work, and/or a physical examination, and such medications shall be used only by me and exclusively in accordance with state and federal law.
11. I agree that these medications are solely for my own personal use, and that I will not share, sell, or trade my medications with any other person or entity. I agree that I will safeguard my medications from loss or theft and will be responsible for their safekeeping.

12. I agree that I will use my medications at the prescribed rate and dosage and will keep the medication in its respective labeled container.
13. I acknowledge that 10X Health supplements and medications may not be NSF certified. Therefore, if I am a professional athlete, collegiate athlete, or if I am otherwise subject to any other restrictions, I agree that I will consult my personal and/or team physician prior to the use of any 10X Health supplements or medication. I further understand and agree that the medication is not being prescribed for me for the purposes of bodybuilding, performance enhancement or physical appearance, and I agree to not attempt to use it for any of these purposes.
14. I acknowledge that I have the right to receive my prescribed medication at the pharmacy of my choice, provided my medication is available at such pharmacy.
15. I agree that I will not attempt to obtain additional or other medications from any other health care practitioner or source without first disclosing my current medication usage to 10X Health, my treating healthcare provider through 10X Health and any other physician, pharmacy or source. I understand that in addition to endangering my health, I may also be violating the law if I fail to make this disclosure.
16. Having been informed of the potential risks of hormone replacement therapy, I voluntarily assume any and all risks which may be associated with engaging hormone replacement therapy.
17. I have discussed and understand the risks and benefits associated with 10X Health products and services and I agree that I will immediately report any adverse side effect related to the use of my medication to 10X Health and discontinue use until advised to resume usage by a healthcare provider. If I elect to receive intravenous therapy (commonly referred to as an IV) or vitamin injections, I hereby acknowledge that I have discussed the benefits and risks to IV therapy.
18. I understand that most, if not all, products and services offered by 10X Health are not evaluated by the FDA. 10X Health products and services are not intended to diagnose, treat, cure, or prevent disease.
19. I understand that the healthcare providers in the 10X Health healthcare provider network are available for questions and/or concerns during normal business hours throughout the course of my treatment.
20. I agree and understand that any returns, replacements and refunds will be subject to 10X Health's **Refund Policy**
21. I understand that these programs are not covered by insurance. I understand that I am responsible to pay for all services and products and I will pay for all such products and services in advance. I will not directly or indirectly seek reimbursement through my insurance company, Medicare, Medicaid, or other third party. I understand that neither 10X Health nor the healthcare providers in the 10X Health network will complete or sign any insurance papers.
22. I authorize 10X Health and the healthcare providers in the 10X Health network to perform the procedures necessary and advisable to maintain my medical health and monitor my treatment, including, but not limited to, obtaining my medical history and treatment information, conducting physical examinations, ordering or conducting diagnostic testing (e.g. genetic, gut and blood labs), developing treatment plans and discussing them with other treating physicians and administering medications. I agree to cooperate with 10X Health in managing my treatment including presenting myself for follow-up evaluations and testing.
23. I understand and agree that the healthcare providers in the 10X Health network are not my primary care providers and are not intended to replace my current primary care provider. I understand that my 10X Health supervised treatments will be in conjunction with the care provided to me by my primary care physician. I agree to keep the healthcare providers in the 10X Health network and my primary care physician informed of any changes in my health or adverse reactions to any medications over the course of my treatment.
24. I understand and agree that medicine is not an exact science and therefore any medical treatment offered by 10X Health and their healthcare provider network is not accompanied by any claims, guarantees, promises or warranties.
25. I warrant that all my responses are complete, truthful and accurate. I understand that medications, treatments, or therapies prescribed or administered by 10X Health System may be subject to substance rules of professional sports organizations and anti-doping agencies. I take sole responsibility for ensuring compliance with substance rules, recognizing the potential consequences of violations, and releasing 10X Health System from liability related to prescribed substances. Additionally, I solely assume responsibility for confirming the legality of treatments and agree to indemnify and hold harmless 10X Health for any non-compliance or violation of this form.
26. I understand that any data I provide to 10X Health or its provider network throughout my customer journey is subject to 10X Health's **Privacy Policy.**
27. I hereby consent to allow 10X Health to use and process my personal data for the purposes in this Form and to for 10X Health to contact me through the e-mail and/or phone number (including by automated SMS texts) I provided for promotional and marketing purposes.

Mammogram and Pap Smear Waivers:

If applicable, I, the customer, understand and acknowledge:

I am aware that regular, comprehensive screening for breast cancer, including screening mammography, is medically indicated for my age group. I understand I should follow the recommended guidelines established by the US Preventative Service Task Force.

I am aware that PAP and/or Transvaginal Ultrasound are the best single method for detection of early ovarian, endometrial and/or cervical cancer. I understand I should follow the recommended guidelines established by the US Preventative Service Task Force.

State Specific Disclosures

FLORIDA, MASSACHUSETTS, MINNESOTA, NEW HAMPSHIRE, TEXAS, AND VERMONT RESIDENTS: I understand that my consent allows 10X Health the use of my de-identified genetic information for research and/or education. If I do not give permission my de-identified genetic information may still be used to develop new tests and to improve or confirm the quality of existing tests, including sharing de-identified data with public databases. Aggregate information that includes my genetic information (e.g., summary information like total number of customers tested with a particular variant), may still be shared.

MINNESOTA RESIDENTS: I understand that my consent to disclose genetic information as described in this form is valid for a period of one year from the date I sign this Form.

WYOMING RESIDENTS: I understand that I have the right to inspect, correct, and obtain my genetic information and request destruction of my genetic information under certain circumstances in accordance with Wyoming Statutes § 35-32-103. However, 10X Health may deny my request to destroy my genetic information under certain circumstances, including if retaining my information is necessary for one of the purposes described in this Form.

Customer Signature	Date
Customer Name (please print)	Customer Email Address