LightX App
Consent for the collection and processing of personal information

LightX Innovations Inc. ("**LightX**") has designed a smartphone application (the "**LightX App**"), which allows its authorized users, namely healthcare professionals using LightX devices (the "**healthcare professionals**") to take and upload photos of their patients' eyes, as considered necessary or desirable by such healthcare professionals when offering medical assistance to their patients.

1. I, understand that: **(i)** in order to use the LightX App, my healthcare professional will need to disclose to LightX some personal information about me, namely my name and/or the identifying code used by him/her to identify me and the photo(s) taken of my eye for analysis, by downloading them on the LightX App; **(ii)** my personal information will be encrypted and then processed by the LightX App for analysis purposes, all of which will be made automatically and robotically via algorithms; **(iii)** during the analysis process, my personal information will be stored on Canadian secure cloud-based database until the analysis is completed and then the results of the analysis will be automatically and robotically sent by the LightX App to my healthcare professional (while no copy of such analysis will be retained by LightX); and **(iv)** my personal information (including the analysis) could be retained by my healthcare professional on the LightX database as he/she deemed required to provide me with the medical assistance that I need (the **Authorized Purposes**). **I consent to the download of my personal information by my healthcare professional on the LightX App for the Authorized Purposes, and to the use, storage and other process of my personal information by LightX via its LightX App for the Authorized Purposes** [__] [__]

Yes **No**

I understand that I can refuse to consent by informing my healthcare professional (without giving any reason), and that such refusal will have no impact on the quality of care to which I am otherwise entitled or on my relationship with that healthcare professional (provided that should I refuse that my personal information be used, stored and processed for the Authorized Purposes my healthcare professional will not, in such case use LightX App).

2. I further understand that LightX could in compliance with applicable law: **(a)** retain a copy of the photos downloaded, which will be anonymized by irremediably removing all identifiers that could directly or indirectly identify me (subject to the photos of my iris and retina which would by their nature remain personal information even if my name/identifying code is removed) for use on an aggregated basis for artificial intelligence training purposes; and **(b)** use the anonymized information for any other purposes, as such information will no longer constitute personal information. **I consent to the to the secondary uses of my personal information.** [__][__]

Yes **No**

I understand that I can refuse to consent to the secondary uses of my personal information (under point 2 (a)) for any reason. Such consent is distinct from the consent requested under point 1 and is not required to perform the Authorized Purposes.

3. I confirm that have been informed of and understand the purposes for disclosing and having my personal health information stored and processed via the LightX App.

4. **I understand that my consent(s) can be withdrawn at any time,** provided that the personal information about me already anonymized will not be destroyed (as being in a format that no longer allows LightX to re-identify me).

5. **I understand that I can exercise my right of access or of rectification by contacting my healthcare professional,** as LightX is only holding my personal information on his/her behalf on a temporary basis.

6. I understand that this consent form is available in French and I confirm my express wish to use the English version. **Je comprends que ce formulaire de consentement est disponible en français et je confirme mon intention expresse d'utiliser la version anglaise.**

Signature of patient or substitute decision maker

☐ I am the requester and I am 14 years of age or older

☐ I am the requester's parent with custody, or a person lawfully entitled to consent on behalf of the requester who is under 14 years of age

☐ I am the requester's curator, tutor, advisor or mandatary, or exercising a power of attorney for the requester who is an incapable adult, I am entitled under the powers granted to me to make the present request and the communication is necessary for the exercise of these powers.

Signature: _____ Date: