Consent for Medical Doctors
"The International Dysferlinopathy Registry"

I give my permission for the International Dysferlinopathy Registry to display my contact information below in the online *Registration and Consent Questionnaire (I)* -to be completed by the patient.

If one of my patients registers with the International Dysferlinopathy Registry and indicates me as his/her doctor / medical centre, I allow the International Dysferlinopathy Registry to contact me to request medical (genetic/biological/clinical) data for this patient.

I agree to fill out the *Registration Questionnaire (III)* –to be completed by the medical doctor- with the requested information that I have in my possession for this patient and to send it back to the International Dysferlinopathy Registry in a timely manner.

Full name of health professional (***mandatory***): _____

Phone number **(mandatory)**: _____

E-mail **(mandatory)**: _____@_____

☐ Physician ☐ Neurologist ☐ Consultant ☐ Other: (*please specify*) _____

Name of medical centre / hospital (*if applicable*): _____

Postal address: _____

_____

_____

City: _____

State/Province: _____

Postal/Zip Code: _____

Country: _____

Professional's signature: Date:

_____ _____

Please send this *Consent for Medical Doctors* form, correctly completed and signed, by e-mail (contact@dysferlinregistry.org) or by post to: The International Dysferlinopathy Registry, Inserm UMR 910, Aix-Marseille Université, 27 boulevard Jean Moulin, 13385 Marseille Cedex 05, FRANCE.