Manente NC, P.C.
AUTHORIZATION FOR PHOTOGRAPHY AND/OR AUDIO RECORDING

Patient Name: ______________________________________

Patient Date of Birth: ______________________________________

I hereby authorize:

Manente NC, P.C. ("Practice") to use and disclose information about me including photography, audio and video recordings of me (herein referred to as the "Materials"), as well as to hire third-parties to create the Materials on Practice's behalf.

The information about me may include my: treatment, age, duration of treatment, diagnoses, city and state of residence, photographs, location of the Practice treating locations(s) and information about my life and how I came to Practice or my on-going treatment. The information may also be disclosed to external media in the form of press releases, stories, photographs or video clips. It may also be used for internal purposes or on the Practice website or through Practice's own marketing or educational campaigns. I understand that my identity may be indirectly disclosed or discernible in Materials, though my name will not be published in Materials unless specifically agreed to below.

☐ I do ☐ I do not consent to the use of my name in conjunction with the Materials.

Practice will not receive any direct or indirect payment from or on behalf of any third party in exchange for the release of this information about me. I understand that I will not receive any payment for use of the Materials.

I understand the provision of health care treatment, payment for my health care and my health care benefits are not dependent on this authorization. I understand I am not required to sign this authorization, however, the information will not be used or disclosed without authorization. I understand any information used or disclosed pursuant to this authorization may be subject to redisclosure.

I understand I have the right to revoke this authorization in writing, except to the extent information has already been released pursuant to this authorization at the time of the revocation. I can revoke this authorization by sending correspondence to the Manager or Privacy Officer of Practice.

I hereby release, discharge and agree to hold Practice harmless from any liability that may arise from the release of information authorized above.

This authorization will remain in effect for three (3) months beyond the completion of treatment.

______________________________________ ____________________
Signature of Patient or the Patient's Personal Representative — Date

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Print Name

If the patient is a minor or has a personal representative, by signing this form, I represent that I am the legal parent/guardian/personal representative of the Patient named above and I am not prohibited by law from releasing access to the requested information.