American Health Partners, Inc.
201 Jordan Road, Suite 200
Franklin, TN 37067

AUTHORIZATION FOR USE OF IMAGE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, I hereby authorize American Health Partners, Inc. and its subsidiaries (collectively referred to herein as "COMPANY" to photography, video, interview, or make audio recordings of me, which may include certain elements of my protected health information (PHI). Such photographs, films, audio recordings and/or interview content may disclose the fact that I am, or have been, a patient of the COMPANY and may contain other information about me and facts that can be inferred from the photographs or film.

I agree to grant COMPANY the absolute right and permission to use and disclose, and to authorize others to use and disclose, my image or likeness for promotions, publicity, illustrations, brochures, advertising, media releases, website content, newsletters, or magazines, in any manner, medium or form, whether now known or hereafter existing. I release and relinquish any and all rights I may have to the use of my photograph, testimonial, video and/or audio recording for the purposes stated herein, and understand that my photograph, testimonial, video and/or audio recording will not be returned. I further waive the right to inspect or approve the finished product, including written or electronic forms where my likeness appears.

I agree to the use of third parties to capture my image and/or voice and understand that my information will be used and disclosed by these third parties as instructed by the COMPANY. I understand the publication and distribution of the protected health information related to this disclosure may include distribution to the general public for marketing purposes and I waive any right to royalties or other compensation arising out of or related to the use of my image.

I understand that I have the right to revoke this authorization in writing, except to the extent that COMPANY has already relied on this authorization to create or release marketing or other promotional materials featuring my image, likeness, testimonial, audio recordings of my voice, my name and/or other information. I understand and agree that this authorization shall remain in effect until all such marketing and/or promotional materials in existence at the time of any revocation of this authorization have been distributed, disseminated or expire. Any revocation of this authorization will become effective only after all marketing and/or promotional materials are distributed, disseminated or expire. I understand that, in order to revoke this authorization, I must notify COMPANY's Privacy Officer in writing at American Health Partners, 201 Jordan Road, Suite 200, Franklin, TN 37067.

I understand the information disclosed pursuant to this authorization may be re-disclosed by anyone who views or receives it, in which case the information would no longer be protected by the Health Insurance Portability and Accountability Act of 1996 or any other state or federal law or regulations.

I agree to release the COMPANY, its employees, officers, parent company, and affiliates from any legal responsibility or liability for disclosure of my information as described herein, and I hold harmless and release and forever discharge COMPANY from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I understand and acknowledge that this authorization is voluntary and that I may refuse to sign this authorization.

I understand that COMPANY will not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.

Check as applicable:

☐ **I grant permission** for my name to be used with my photograph, testimonial, and/or recordings.

☐ **I do not grant permission** for my name to be used with said photograph, testimonial and/or recordings.

By signing below, I fully understand the contents, meaning, and impact of this release.

Signature of Individual or Legal Representative (if under age 18): _____

Relationship of Legal Representative: _____

Print Name: _____ Date Signed: _____

Address: _____

Phone: _____ Email: _____

Company Representative: _____ Date Received: _____