Medical Services of America, Inc.

Photo / Video / Audio Consent & Release Form

INSTRUCTIONS: THIS FORM IS INTENDED TO ACKNOWLEDGE/CONFIRM YOUR UNDERSTANDING. YOUR SIGNATURE BELOW INDICATES YOUR APPROVAL AND AGREEMENT WITH ITS CONTENTS:

❏ I, the undersigned, agree and authorize Medical Services of America, Inc. to conduct photography, video recordings, or audio recordings for any/all of the following purposes:

- **Publicity and advertising materials, including printed publications and newsletters**
- **Presentations, conference and exhibition materials**
- **Websites, social media channels and digital communications**
- **News media and their associated websites and social media channels**
- **Partnering organizations and their associated websites and social media channels**
- **For advertising purposes including print, television and radio**
- **For identification purposes in connection with my care and treatment**
- **For online testimonials and reviews**
- **For educational purposes in connection with medical research and community education**

❏ **Other purposes (please specify):** ______________________________

❏ I agree that such interviews, recordings, articles, quotes, photographs, films, audio or video and/or any reproductions of same in any form, will become property of Medical Services of America, Inc. and I relinquish any present or future claim for reimbursement for said photographic or film reproduction of my likeness or for said testimonials by me.

❏ I hereby release Medical Services of America, Inc. its affiliates, employees, representatives and agents from any and all claims, demands, costs and liability that may arise from the use of these interviews, recordings, photographs, videotapes or films, and/or any reproductions of same in any form, as described above, arising out of being interviewed,

❏ I hereby waive all rights and release Medical Services of America, Inc. from any claim and/or cause of action, whether now known or unknown, for defamation or invasion of right to privacy, publicity or personality or any similar matter, or based upon or relating to the use and exploitation of my name, image and likeness in connection with the aformentioned purposes.

❏ I acknowledge that I have read this consent form in its entirety, or it has been read (or translated) to me, and I have had the opportunity to ask questions about it and understand it.

❏ I understand I have the right to withdraw this consent at any time by sending a formal written request via email to: "**privacy@msahealthcare.com**," or by mail to: **Medical Services of America, Inc., Attn: Privacy Officer, PO Box 2431, Lexington SC 29071-2431**

By signing below, I am aware that my protected health information will exist forever in either a recorded, printed, and/or electronic version or other version as may develop over time and that once it is published or disclosed in any form it will continue to be used. I understand that information about me used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state law.

Print Name of Patient/Subject: ______________________ **Time:** __________

Signature of Patient/Subject: ______________________ **Date:** __________

Print Name of MSA Representative: ______________________ **Time:** __________

Signature of MSA Representative: ______________________ **Date:** __________