Patient Authorization and Release

PATIENT AUTHORIZATION FOR PHOTOGRAPHY, VIDEOTAPE, AUDIOTAPE AND INTERVIEW USE AND RELEASE

I authorize Valley Care Clinics Weight Loss Surgery Center and/or its subsidiaries, partnerships, limited partners, general partners, parent companies or affiliates including but not limited to Universal Health Services, Inc. and UHS of Delaware, Inc. (collectively referred to throughout this document as "Valley Care Clinics Weight Loss Surgery Center") to photograph, videotape, audiotape or interview me, and I authorize Valley Care Clinics Weight Loss Surgery Center to publish and use such materials or any portions thereof in its sole discretion and in any manner it desires including but not limited to informing and educating the public as well as to commercially promote, advertise and/or market the services of the hospital. I hereby waive any right to compensation for Valley Care Clinics Weight Loss Surgery Center's use such materials which may display my likeness, photographs, image, voice, statements and name and release Valley Care Clinics Weight Loss Surgery Center and its employees and agents from liability for any causes of action or claims of damages relating to Valley Care Clinics Weight Loss Surgery Center's use of such materials including but not limited to any claims of invasion of privacy, defamation, infringement of my right of publicity, copyright infringement. I understand and acknowledge that any photograph, videotape, audiotape or printed or published materials could be reproduced by unknown persons or organizations and republished via internet or other media without my knowledge or consent.

I recognize and understand that I may be providing and disclosing my protected health information of which I would have the right to full confidentiality and privacy. I authorize Valley Care Clinics Weight Loss Surgery Center to publicize and/or reproduce such protected health information as referenced above and release and waive any claims against Valley Care Clinics Weight Loss Surgery Center, its employees, agents, officers and directors from any causes of action or claims of damages relating to the disclosure of such information and the privacy requirements

of the Health Insurance Portability and Accountability Act (HIPAA) or any other law. As referenced below, I have the right to revoke this authorization. However, I acknowledge and agree that any revocation of this authorization will not change any actions that Valley Care Clinics Weight Loss Surgery Center took before I did so and it will be able to use and disclose the information I provided prior to the revocation.

________________________ ________________________
(Name—Please Print) (Date of Authorization)

________________________ ________________________
(and/or Representative) (Relation)

________________________ ________________________
(Street Address) (Phone)

____
(City/Zip)

____
(Signature)

Patient – Please Note

1. You have the right to request cessation of recording or filming.
2. You may revoke your authorization at any time by sending notice, in writing, to the Marketing Department of this hospital.
3. Your authorization will expire within 3 years of the date you entered above.
4. Treatment, payment, enrollment and eligibility for treatment in this hospital are not affected by your agreement or refusal to give your authorization.
5. You are entitled to have a copy of your signed authorization.
6. Disclosure of a videotape, photograph, audiotape or interview to the general public could result in their republication by unknown persons without your/our knowledge or consent and federal privacy laws will not protect it.