SILK VISION
& SURGICAL CENTER

PATIENT MEDIA CONSENT RELEASE

CONSENT FORM AND WAIVER

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION
AND/OR PUBLIC USE OF IMAGE (PHOTOGRAPH OR VIDEOTAPE)
FOR MEDIA AND PUBLIC RELATIONS PURPOSES

I hereby give consent to **SILK VISION AND SURGICAL CENTER** to take and use images (photographs or videotape) or sounds recordings of me and/or the minor patient or person named below for whom I am giving consent, and disclose confidential patient information about me and/or the minor patient or person, to or in any public media, including radio, television, internet or print, or in a medical publication. I understand that the intended use of such images and confidential information is for advertising, marketing, fundraising or promotional purposes of Silk Vision and Surgical Center. I understand that confidential information to be disclosed may include information about the patient's treatment at **SILK VISION AND SURGICAL CENTER** obtained from interviews of the family, physicians and hospital personnel, or from the patient's medical records, including photographs, videotapes and results of diagnostic studies, and I hereby waive the right to or interest in the confidentiality of this patient information or images taken and disclosed to the public, as contemplated in this release.

I acknowledge that this consent and authorization for release of confidential information is being made solely for the benefit of **SILK VISION AND SURGICAL CENTER** and without any expectation of compensation or other benefit to the minor patient or person or the family thereof. To the extent that any benefit accrues or might accrue to Silk Vision and Surgical Center from the use of images or disclosure of information, I hereby and forever waive any interest in or claim to such benefits.
I hereby release and forever discharge **SILK VISION AND SURGICAL CENTER** (including without limitation all corporate affiliates and officers, directors, trustees, employees, medical staff members and agents) from any and all claims, liability, actions, suits, demands, costs, expenses or indebtedness arising out of, related to, or in any way connected with the use of images or disclosure of the information and materials described herein, and I hereby waive all rights and interest in and to such information and materials.

I have been informed that once this information is disclosed it may no longer be protected by federal privacy regulations. I have been informed that this authorization is voluntary and is subject to revocation at any time, except to the extent that action has been taken in reliance thereon, by notifying **SILK VISION AND SURGICAL CENTER** in writing to:

_____ _____

Patient signature Date:

_____ _____

Witness signature Date: