PATIENT & FAMILY - 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 Glow, MD and The Clinics of North Texas LLP (hereinafter "Clinics") 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 Glow, MD or Clinics publication. I understand that the intended use of such images and confidential information is for advertising, marketing, fundraising or promotional purposes of Glow, MD or Clinics.

I understand that confidential information to be disclosed may include information about the patient's treatment at Glow, MD or Clinics obtained from interviews of the family, physicians, and clinic personnel, including photographs, 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 Glow, MD or Clinics 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 Glow, MD or Clinics 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 Glow, MD or Clinics (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 understand that I have the right to request cessation of recording or filming at any time. I understand that this Authorization will be in effect indefinitely unless otherwise specified here:
_____

I have been informed that any films, videotapes, photographs and/or interviews relative to this Authorization shall not be considered part of my medical record. Such films, video tapes, photographs and/or interviews are the property of the Glow, MD and Clinics and may be destroyed at any time at the discretion of the Glow, MD or Clinics.

I understand that whether I agree to participate or decide not to participate in the Product, the decision will in no way affect the care or treatment provided to me by the physicians or staff of Glow, MD or Clinics.

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 Glow, MD and Clinics in writing at: Marketing and Public Relations Department, 501 Midwestern Parkway East, Wichita Falls, TX 76302

Name of Minor Patient or Person (please print) _____

Date of Birth of Minor Patient or Person _____

Zip code _____

Name of Consenting Individual, Parent or Guardian _____

Relationship to Minor Patient or Person _____

Phone number _____

Email address _____

Today's date_____

Signature of Consenting Individual, Parent or Guardian _____