PATIENT SERVICES INCORPORATED ("PSI")
Authorization to Use and Disclose Health Information

I authorize the use or disclosure of my health information, as described below:

1. *Patient Services Incorporated ("PSI") is authorized to use or disclose my protected health information as stated:* I have electronically submitted information about my life and the impact that the services that PSI has made available to me have had on my life. This information includes my personal descriptions, statements and reflections on the impact of such services, as well as photographs of me that help illustrate my story. I understand that the writings that I have submitted are personal in nature and may directly or indirectly reveal protected health care information about me. Nonetheless, it is my desire to authorize and consent to the use by PSI of any and all of information that I have submitted on PSI's website, social media platforms, in PSI's printed literature, and as part of any electronic and written presentations by or about PSI. I consent to PSI's use of my portrait or picture as well as the use of my name and identity in all materials however displayed. In addition, I consent to PSI's use of my testimony in video if applicable. I waive all rights, claims or interest that I may have to control my name, photograph and identity as displayed pursuant to this Authorization.

2. *Name(s) of organization(s), person(s) or class of persons who may receive and use the information:* I understand that all the information that I consent to being used by PSI under this Authorization to use and disclose health information will be available over the internet for viewing by the general public. Further, presentations/video presentations of all types will be made to various groups interested in the work of PSI and so all information used under this Authorization should be considered as being available to the general public.

3. *The purpose(s) for which the information will be used or disclosed:* Promotion to the general public, individuals, and corporations of the services provided by PSI to obtain recognition and visibility for its works.

4. *This authorization shall expire on:* 10 years from the date this form is signed/authorized.

I understand that I may <u>not</u> be required to consent to or sign this Authorization as a condition of my ability to obtain treatment or payment nor shall my eligibility for benefits be in any way adversely affected by my refusal to sign this Authorization.

I understand that I may inspect or copy any information used/disclosed under this Authorization.

I understand that I have the right to revoke this Authorization at any time by notifying Patient Services, Inc. in writing.

I also understand that information disclosed pursuant to this Authorization could be subject to redisclosure by the recipient and would no longer be protected by privacy rules.