AUTHORIZATION AND RELEASE

For Patients and Residents

I hereby authorize Aegis Therapies, Inc. ("Aegis Therapies"), and/or its representative(s), to use the following information and materials that may include my protected health information:

Check all that apply:

☐ Photographs of me ☐ Video and /or audio recordings of me ☐ Statements I have made or written

☐ A description of the care and treatment that is being provided to me

By signing this form, I authorize Aegis Therapies to disclose this information to the general public for purposes of illustration, promotion, art, editorial, advertising, training, or any other marketing or public relations initiatives.

No money will ever be due to me from any source as a result of the publication, use, or disclosure of my information, personal image, testimonial or other materials that I have authorized to be used or disclosed by this Authorization and Release.

A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this Authorization, as provided by federal and/or state law. However, I waive the right to approve the finished copy of any electronic or printed material that is produced using the information and materials I have authorized above. This release shall be binding upon me and my heirs, legal representatives, and assigns.

NOTICE TO PATIENT/PATIENT REPRESENTATIVE:
The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA" regulations). Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by applicable federal and/or state confidentiality rules in such circumstances.

I understand that I can revoke this Authorization at any time by notifying Aegis Therapies' Compliance Officer, in writing, at the following address: **Compliance Officer**, **Aegis Therapies, 1000 Fianna Way, Fort Smith, AR 72919.**

A revocation will be effective as of the date it is received by Aegis Therapies. If I do not revoke this Authorization, it shall expire on _____ [insert date] or ten (10) years from the date this Authorization is executed, whichever is sooner. I understand that my revocation will not apply to any information, including protected health information, that has already been used and/or disclosed before the revocation is received.

I release and discharge Aegis Therapies from all liability, including liability for negligence, that in any way arises out of:

- any and all rights that I may have or may have had in the photographs, videotapes or other materials of me that I have authorized to be used and disclosed in this Authorization; and
- any claim that I may have or may have had relating to such use and disclosure of those photographs, videotapes, or other materials of me, including any claim for payment in connection with any distribution of them in any published medium identified in this form.

This Authorization is a voluntary contribution. I understand my treatment, payment, enrollment or eligibility for benefits is not dependent on this Authorization. I certify that I have read this Authorization and Release carefully and fully understand its terms. If I have questions about the use or disclosure of my photographs, videotapes, or other materials of me, I may contact Aegis Therapies' Compliance Officer at 972-372-6300.

_____	_____	_____
Patient's Name (printed)	Patient's Signature	Date
_____	_____	_____
Personal Representative's Signature (if applicable)	Personal Representative's Relationship (if applicable)	Date

INSTRUCTIONS FOR AEGIS THERAPIES STAFF: Please retain the original copy in corresponding file, and submit completed signed form with facility name and facility number via consent@aegistherapies.com