PATIENT STORY/TESTIMONIAL: PERSONAL CONSENT AND RELEASE

IMPORTANT NOTICE TO PATIENT STORY/TESTIMONIAL PARTICIPANTS. Please read this personal consent and release ("Consent") carefully before agreeing to its terms and participating in the "Patient Story" interview ("Interview") and testimonial ("Testimonial"). This is a legal and binding contract between you and Peter Millett, MD ("Physician"). This Consent contains information related to the use, disclosure, and ownership of your story, images and other information you provide to Physician and your participation in the Interview/Testimonial. By participating in the Interview/Testimonial, you acknowledge that you understand and agree to be bound by the terms set forth in this Consent. If you do not agree to the terms of this Consent you will not be authorized to participate in the Interview/Testimonial.

By signing this Consent, I grant Peter Millett, MD and his representatives permission to use my story/photo/video on his public website drmillett.com and for promotional purposes and, if applicable, to disclose my health information.

1. If provided, I authorize Peter Millett, MD publication of my name/my child's name, photo/likeness/video and all or part of my/his/her testimonial/quotes.

2. I authorize this use in various Peter Millett, MD, The Steadman Clinic and the Steadman Philippon Research Institute-sponsored materials such as, but not limited to, newsletters, brochures, web pages, social media websites and videos promoting the company's products and/or services. I understand that my story/photo/video will also be accessible from and searchable on the Internet.

3. I authorize Peter Millett MD's release of this information to media representatives for the purpose of promoting his practice services.

4. I understand that Peter Millett, MD will not receive any direct payments for the disclosures.

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain Peter Millett, MD's, services, other treatment, or otherwise affect my healthcare eligibility.

6. This authorization will remain in effect until I revoke it by providing written notice to Peter Millett, MD.

7. I understand that if I request it, Peter Millett, MD will provide me a duplicate copy of this authorization. I acknowledge that I can download a copy of this authorization from this form.

8. (Where applicable) As a patient, I understand that this use potentially discloses personal health information, as covered in my testimonial.

9. I understand that I may revoke this authorization at any time by providing written notice as set forth in Peter Millett, MD's Privacy Policy. However, I understand and agree that if I revoke this authorization, Peter Millett, MD is not responsible for notifying those to whom he has disclosed this information, including media representatives or search engines, such as Google or Yahoo!

10. I acknowledge that I have been provided a copy of Peter Millett MD's Privacy Policy and that I may request a copy of the same at any time by contacting Peter Millett, MD's office in writing.

11. I understand that once disclosed, my health information may be subject to re-disclosure, at which point it is no longer subject to federal privacy laws.

By checking "agree", I represent and warrant that I am legally entitled to enter into this Consent and that I acknowledge that this Consent constitutes a legal, valid and binding obligation.