

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR SOCIAL MEDIA USE

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable State law) to use or disclose an individual's protected health information, in connection with the fertility treatment received at a Clinic within the Prelude Network. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made: Full Name: _____ Other Name(s) Used: _____ Date of Birth: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone: (____) _____ Email (Optional): _____	
Information regarding health care provider or health care entity authorized to disclose this information: Name: The Reproductive Medicine Group, LLC Address: 5245 East Fletcher Avenue, Suite 1 City: Tampa State: FL Zip Code: 33617 Phone: (813) 914-7304 Fax: (813) 914-7314	
Information regarding person or entity who can receive and use this information: Name: Inception Fertility Holdings, LLC its subsidiaries and affiliates Address: 4828 Loop Central Drive, Ste 900 City: Houston State: Texas Zip Code: 77081 Phone: (713) - 300 - 1123	
Specific information to be disclosed: ☐ Other: use of my family's recordings, photographs, portraits and pictures in which any of our names, voices and likenesses may be included related to the treatment received at Covered Entity.	
Reason for release of information: ☐ Other (Specify): Testimonial regarding treatment provided at a Prelude Network Clinic	
Notwithstanding the forgoing release, the information below will not be released: _____ Drug, Alcohol or Substance Abuse Records _____ Mental Health Records (Except Psychotherapy Notes) _____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)	By signing below, you acknowledge the following information may be released: _____ Genetic Information (Including Genetic Test Results)

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of fifty (50) years after the death of the patient for whom this authorization is made or the following specified date:

Month: _____ Day: _____ Year: _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization will not include disclosure of information relating to **DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except

psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**. It may include **GENETIC INFORMATION** only if I place my initials on the appropriate line above. In the event the health information described above includes Genetic Information, and I initial the corresponding line in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

CONSENT TO USE RECORDINGS, PHOTOGRAPHS IMAGES, PORTRAITS AND PICTURES

By signing below, I grant to The Reproductive Medicine Group, LLC and its affiliates and those acting for it (Prelude Fertility) the irrevocable, perpetual, unrestricted right and permission (unlimited as to the number of uses, times and territory) to display, modify, use, create derivative works based upon and publish for promotion, advertising, trade and any other purpose whatsoever, recordings, photographic images, portraits and pictures of me and my family and including minor children (my family) in which any of our names, voices and likenesses may be included, including all images and recordings made, published or displayed through any and all media now existing or later developed, including printed materials, electronic publications, brochures and Internet postings.

I acknowledge and agree that the use of my family's recordings, photographs, portraits and pictures may reference reproductive medicine, including in vitro fertilization and other fertility services received at The Reproductive Medicine Group, LLC and disclose that I received treatment at The Reproductive Medicine Group, LLC. I understand and acknowledge that such use may give rise to the impression that my minor child was conceived using these services. Notwithstanding the foregoing, I consent to such use.

I understand that neither I, nor anyone in my family, will have the ability to and I waive any right to examine or approve any completed product, advertising copy or printed matter containing any photographic image, portrait or picture of me or my minor child in which his or her name, voice and likeness may be included. I understand that my family will not receive any compensation of any kind in return for the rights granted hereunder.

On behalf of my family, I release The Reproductive Medicine Group, LLC from any claims or liability now or in the future existing relating to the rights granted herein, claims for libel or invasion of privacy and claims relating to any use, non-use or editing of the recordings, photographic images, portraits and pictures of me and my family.

I am over the age of 18 and have the right to contract in my own name and, being a parent or guardian of the below-listed minors, consent and agree to this release with respect to the below-listed minors. I have read this General Consent and Release prior to agreeing to it and fully understand it.

SIGNATURES

Patient Signature

Printed Name

Date

Partner Signature

Printed Name

Date