AUTHORIZATION

Authorization For Video, Audio, Recording,
and Photographic Participation and Interviews

Subject's Name: ______________________________

Address: ______________________________

Telephone: (________) ____________________ **E-mail:** ____________________

☐ This authorization pertains to a specific project, request, event and/or use (specify):

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I authorize CarepathRx to photograph (still photo, film, videotape, or digital imageryv/ideo), record (audiotape or digital) and/or interview me, using either a CarepathRx staff photographer/videographer and/or reporter, or a photographer/videographer and/or reporter approved by CarepathRx. I understand that CarepathRx, and in some cases the organization with which it has partnered, has/shall have all legal rights to the photography/recording(s)/interview(s) and that I give up any and all rights to these organizations and will not receive any payment or compensation for the same now or in the future. I understand the photography/recording(s)/interview(s) may be used for publicity, education, public information, or paid advertising by CarepathRx and that the photography/recording(s) could appear on CarepathRx's website and/or elsewhere on the Internet. I hereby release and discharge CarepathRx, its subsidiaries, and its and their emplyoees, agents, and representatives from any claims, liability, or results caused by the use of such photographyre/cording(s) and/or interview of me as provided herein. By agreeing to be interviewed about health care services received from CarepathRx, I also authorize CarepathRx, at its discretion, to interview my CarepathRx doctor(s), nurses(), and/or other caregivers to confirm, supplement, and/or clarify the information provided in my interview. I understand that such staff interview(s) may result in a limited disclosure of my protected health information (PHI), in the form of facts necessary to ensure the accuracy of any account based on my interview, but that no medical records will be released.

I understand that whether I choose to sign this authorization will in no way influence the health care services provided to me by CarepathRx. Additionally, I understand that I will not receive any special services or compensation in exchange for my agreeing to sign this authorization. I understand that I may revoke this authorization at any time by providing written notice to CarepathRx addressed to: CarepathRx Marketing Communications, 600 Grant St. Floor 22, Pittsburgh, PA 15219. However, such revocation shall not affect CarepathRx's right to use information, photography / recording(s), and / or interviews made or obtained prior to Smuyb rjeecvto'cation of this authorization.

Subject's Signature: ______________________________ **Date:** ____________

Witness's Signature: ______________________________ **Date:** ____________

The subject is unable to consent on his/her own behalf because ______________________________

I am the authorized representative of the subject, on the following relationship or basis ______________
______________________________ and hereby provide such authorization on behalf of the subject.

Signature of Subject's
Authorized Representative: ______________________________ **Date:** ____________

CAREPATHrx