



AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION

As consideration for potentially being selected to participate in the MEDI-WEIGHTLOSS CLINICS® national marketing program (the “Marketing Program”) I, _____, hereby grant authorization to MEDI-WEIGHTLOSS FRANCHISING USA, LLC, a Florida limited liability company, its affiliates and its employees (“you”), to use my photographs and/or testimonials and to publish, republish, make, use, reuse, reproduce, modify, and create derivative works of these photographs and/or testimonials at their sole discretion in any and all media now known or hereafter devised, including but not limited to distribution on the worldwide web, television, DVD, video, electronic, direct TV and radio and print advertisements, box insets, brochures, sales collateral, ect., for any purpose and to utilize my likeness in part or in its entirety as they see fit.

I hereby exclusively grant, assign, and convey, all right, title and interest, including any moral rights, in my personal photographs and/or testimonials, and hereby release and agree to hold harmless you, your representatives, employees, officers, directors, agents or any person or persons, corporation or corporations, or affiliate acting under your direction, including any firm publishing or distributing the finished product.

I hereby waive any right to inspect or approve the form of such materials bearing my likeness that all advertisements, box inserts, promotional material, and all copyright and other proprietary interests of whatever kind in the works acquired shall be the exclusive property of Medi-Weightloss Franchising USA, LLC. I also agree to cooperate fully by executing all necessary documents to perfect or register or, if necessary, assign copyright for the exclusive benefit of Medi-Weightloss Franchising USA, LLC. I understand that by signing this Authorization, I specifically waive any claim which I may have for payment or remuneration of any kind.

I understand that this Authorization is voluntary and that the information to be disclosed may be protected by law. I understand that the recipient of the information is the general public and, as such, the information disclosed may be re-disclosed and utilized by the recipient without my knowledge or consent and therefore the privacy of my personal and health information, if applicable, will no longer be protected by federal privacy regulations.

This Authorization will remain in effect for a period of at least twenty-five (25) years. I understand that I may revoke this authorization at any time by notifying Medi-Weightloss Franchising USA, LLC, in writing of my desire to revoke it. However, I understand that the revocation will not be effective to the extent that Medi-Weightloss Franchising USA, LLC has already acted in reliance on this authorization and any changes in consent will only apply from the date of receipt by Medi-Weightloss Franchising USA, LLC. Any existing material in which the image or testimonial is used will not be withdrawn from use.

I acknowledge that I have received a copy of this authorization and I understand that I am not required to sign this authorization as a condition of eligibility for enrollment and treatment under Medi-Weightloss Clinics® weight loss and weight-management program. I also understand that I may not be selected for the Marketing Program and Medi-Weightloss Franchising USA, LLC will have option to destroy my photographs and/or testimonials and they will not be returned to me.

I acknowledge that I have read and understand this Authorization and that, by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

Signature of Person Giving Authorization

Date

Printed Name

Patient E-mail Address

Clinic Name

Patient Phone Number(s)

Witness

Date

