Today's: Date ______________________

Surgical Procedure(s)/Treatment(s): ______________________

Date of Procedure(s)/Treatment(s): ______________________

AUTHORIZATION AND RELEASE of protected health information, diagnostic imaging studies and photographs related to surgical procedure and treatments.

I understand my protected health information records of treatment at Advanced Orthopedics and Sports Medicine Institute, PC (hereinafter called "AOSMI") may be used in connection with publicizing and promoting AOSMI. I authorize AOSMI, to use my name, brief biographical information, images, and diagnostic imaging studies related to the surgical procedure or treatment stated above.

I hereby irrevocably authorize AOSMI, to copy, exhibit, publish or distribute my medical information for purposes of publicizing AOSMI's services or for any other lawful purpose. This information may be used in printed publications, multimedia presentations, on websites or in any other distribution media. I agree that I will make no monetary or other claim against AOSMI for the use of the statement.

In addition, I waive any right to inspect or approve the finished product, including written copy, wherein my information appears. I hereby hold harmless and release AOSMI from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I have read the authorization and release information and give my consent for the use of my medical information and imaoes as indicated above.

Signature: ______________________

Printed Name: ______________________

Home Phone: ______________________ Cell Phone: ______________________

Email Address: ______________________

Street Address: ______________________

City, State, Zip: ______________________