Dialysis Clinic, Inc.

A Non-Profit Corporation

PATIENT AUTHORIZATION

I, _____, am a patient at the Dialysis Clinic, Inc. ("DCI") clinic located at _____ ("Clinic"). I understand that _____ (affiliated with DCI) desires to videotape, photograph, and/or possibly interview me and may use my name, age, dialysis location and health history. (Example - Patient Name, 51 yrs. old, 22 years dialysis at Clinic Name, high blood pressure and diabetic). The videotape/photographs and interview may be used for any one, or combination of the following:

- Patient education videos to be shown in the Clinic.
- Education to be shown at future DCI company meetings.
- Pre-ESRD/ESRD patient education to be shown at physician offices, hospitals, health fairs, or other venues offering pre-ESRD/ESRD patient education within the 50 states.
- Other educational uses for DCI
- Public information representing DCI and it's services at events, such as, but not limited to Trade Shows, Job Fairs and Health Fairs
- Promoting DCI through media outlets including but not limited to television, radio, trade magazines, newspapers, internet sites and billboards
- Social media, such as Facebook, Twitter, YouTube, Google+
- DCI's Intranet and Internet websites

I understand and agree that any photographs/video taken are the property of DCI and I relinquish any rights that I may have to said photographs/video. I understand that there will be no financial compensation for my interview or my appearance in the photographs/video, or websites.

The purpose of taking the photographs/video and conducting the interview has been explained to me and I hereby authorize DCI to photograph/videotape and interview me to include while I am on dialysis, for the purposes specified above.

DCI will not condition your right to treatment or payment on your granting this requested authorization. You have the right to refuse to sign this authorization. Except to the extent that we have already relied on it, you have the right to revoke this authorization by doing so in writing addressed to the following:

_____

Privacy Officer – DCI Corporate
1633 Church St. Suite 300
Nashville, TN 37203

A photocopy of this authorization shall have the same force and effect as the original.

This authorization remains in effect until such time the photos/video are destroyed.

The information used or disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by the regulations that require health care providers to protect individually identifiable health information.

I certify that I have read (or had read to me) the above authorization and that I fully understand the nature and purpose of this authorization. I have had the opportunity to ask and have answered any questions that I may have regarding the information contained in this authorization form. I also certify that I am the patient or the patient's duly authorized agent or representative and that I am authorized to execute this authorization.

Signed: _____ Date: _____

_____ _____
(Print Name) Authority of Personal Representative if signing for the Patient

Witness: _____ Date: _____