PEDIATRIX MEDICAL GROUP PEDIATRIX CARDIOLOGY OBSTETRIX MEDICAL GROUP

CONSENT TO BE PHOTOGRAPHED
(To Be Completed by Subject or Authorized Subjects)

1. I hereby authorize MEDNAX Services, Inc., and its affiliated professional corporations Pediatrix Medical Group, Inc., American Anesthesiology, Inc., or any of their affiliated companies (collectively referred to herein as "MEDNAX") to photograph:

_____.
Subject's name

I understand that the photograph(s) may include still photography, digital imaging and/or videotaping.

2. I hereby waive any ownership right in any photograph is taken and understand that such photograph(s) exclusive property of the MEDNAX.
3. I hereby waive any right to review the photograph(s) or to approve the format, style or medium, including, but not limited to, printed or electronic, in which the photograph(s) are used or presented by MEDNAX. I also release, waive and discharge MEDNAX from any and all legal liability and claims that may result from the lawful use or release of the photograph(s).

_____ _____
Signature of Subject or Authorized Representative Date

_____
Printed Name

_____
Address

_____
Relationship to Subject

_____
Witness

AUTHORIZATION FOR THE USE OR RELEASE OF PHOTOGRAPHS AND MEDICAL STATUS UPDATE

Patient Name:_____

1. Subject to the terms and conditions contained in this form, I expressly authorize Pediatrix Medical Group of San Antonio (the "Practice") disclose my child's medical condition and related treatment and photographs, images, and/or videos to healthcare providers who have previously been involved in my child's care and treatment for the purpose of informing them of my child's progress. Furthermore, I authorize the use of my and/or my child's name in connection with this information.*

2. Upon request, I am entitled to receive a copy of this form after I have signed it.

3. I understand that regardless of whether or not I sign the form, the Practice will provide medical treatment.

4. I understand that I may revoke this authorization at any time by notifying the Practice in writing.

5. If I revoke this authorization, I understand that it will not apply to any actions taken by the Practice before it received the revocation.

6. I understand that this authorization will expire ten (10) years after I execute this form, unless I revoke it in accordance with paragraph (5) above or I specify another expiration date or event (if applicable, specify alternate expiration date:_____).

7. I understand that the Company may only use and disclose the photographs, images and/or videos and related health information in accordance with this specific authorization. However, such information may be subject to further disclosure by third parties who are not bound by this authorization.

8. The practice will not receive financial or in-kind compensation for using or disclosing the medical information.

9. I agree that subject to the following limitations, the Company may select and utilize the photographs, images and/or videos that best suit the uses and disclosures authorized in Section 1.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient

_____

Witness

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION