OBSTETRIX MEDICAL GROUP

AUTHORIZATION TO DISPLAY PHOTOGRAPHS IN THE PRACTICE

Patient Name: _____ Date of Birth: _____

I hereby expressly authorize OBSTETRIX MATERNAL FETAL MEDICINE (the "Practice") located at 910 W. 5th Ave, STE: 380 Spokane, WA 99204 to display, for non-treatment purposes, photographs that from time to time I may send to the practice of myself and/or my child(ren).

1. I understand that the photographs may be displayed in a public area of the Practice such as in a waiting or exam room and/or hallway.

2. I understand that medical treatment is not impacted, regardless of whether or not I sign this form.

3. I understand that I may revoke this authorization at any time by notifying the Practice in writing. If I revoke this authorization, I understand that it will not apply to any actions taken by the Practice before it received the revocation.

4. I understand that this authorization will never expire.

5. I understand that the Practice may only use the photographs in accordance with this specific authorization.

6. I understand that the Practice does not remit or receive direct or indirect payment for posting photographs.

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

I have read the above and authorize the use of the photographs as stated above.

_____ _____

Signature of Patient/Patient Representative Date

_____ _____

Print Name of Patient's Representative Relationship to Patient