RECORDING RELEASE AND AUTHORIZATION

I hereby authorize Sono Bello (the "Practice") to obtain and use, for purposes of training, education, andemployee evaluation, the video recording of my consultation and/or examination, including but not limited to images and discussions of all aspects of my health care. I understand the training, education and employee evaluation may be conducted by the Practice and that recordings may be viewed by clinicians and non-clinicians associated with the Practice and/or other entities with whom the Practice has an executed Business Associates Agreement ("BAA"). This release shall not be construed to grant broad authority for use in advertisements, marketing, or other public broadcasts.

I understand the video recording of my consultation and/or examination will involve the disclosure of my health information. I further understand that images and video recordings of me will be shown to others and may include any images, statements and other events which may occur during my consultation or examination, including information disclosed regarding drug or alcohol abuse, psychiatric illness, and HIV or other communicable diseases. I understand that my name, personal healthinformation, visual appearance, health condition, treatment plan, and other personal information disclosed during the consultation or examination and may be viewed by others. While the Practice employ industry standard practices to ensure the privacy of the videos (use of an encrypted connection, individual account names and passwords, secure server access), I understand the privacy of my confidential personal health information on my videos cannot be guaranteed. I am authorizing the Practice to use the information obtained, but nothing contained herein shall relieve the Practice of any obligations, other than those specifically identified in this authorization.

I understand I have the right to revoke this authorization at any time by sending written notification to the Practice. Any revocation will not be effective to the extent the Practice has taken action in relianceon this authorization. This Authorization is valid for one (1) year from the date of consent unless otherwise revoked.

I understand that I am not required to sign this acknowledgement and the Practice will not condition mytreatment or other services on whether I sign this authorization. I agree that I have not been provided with any financial consideration for this consent by the Practice and that I will not be entitled to any additional consideration. I understand that I will not be provided with any free or discounted treatment as a result of the activities described herein.

I agree that all recordings and any reproductions connected therewith are and shall remain the propertyof the Practice. I understand this consultation or examination is not being recorded or maintained for purposes of diagnosis or treatment, and any information obtained during the recording will not be included in my health care record. I further understand that the content of the video recording covers only portions of the consultation or examination and does not include all the information provided to me as part of my visit or any information provided or obtained during subsequent treatment. I understand that the recordings will not be maintained by the Practice, and I hereby waive any right to access these recordings in the future. I understand this does not preclude my request of my other healthrecord information related to my treatment.

Signature: _____ Date: _____

Patient Name: _____