

PLUM

9205 W. Russell Rd. Suite 240
Las Vegas, NV 89148

PLUM EGG DONOR AGENCY LLC INTENDED PARENT(S) AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION AND CONSENT/USE OF PHOTOGRAPHS AND AUDIO/VIDEO IMAGES

Plum Egg Donor Agency LLC (PEDA) is always pleased when clients are willing to communicate the stories, experiences, and information about their treatment/services received at PEDA & their affiliate companies. Sharing your story can help others who are interested in knowing more about the client services provided by PEDA and their affiliated health care providers and can help PEDA promote its mission of service. PEDA respects the privacy of our clients, visitors, and staff. Ensuring that personal and medical information is kept confidential is among our highest priorities. PEDA seeks your permission to use your medical information and your consent to allow us to take and use audio/video/photographic material of you in PEDA's internal and external communications, including medical and general interest publications and medical and patient education information, and distribute such materials online, in print, and in news media (such as TV, radio, newspapers, and magazines). To ensure that PEDA is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to fill out and sign this form. PEDA will keep a copy of your written permission on file.

____ **I DO** give my permission for PEDA to use my or my child's name and share details of my or his/her treatment and experience as a client in communications produced by or on behalf of PEDA, and consent to take and make use of my and/or my child's audio/video/photographic images in publications produced by or on behalf of PEDA. This permission extends both to electronic versions on the PEDA Website and other internet/electronic applications as well as to printed, filmed, and taped versions.

____ **I DO** give my permission for PEDA to release my or my child's name and details of his/her treatment/service to the news and electronic media including, but not limited to, internet/online publications, TV, radio, newspapers and/or magazines, and allow the news media to make images (digital, video, or otherwise) of me or my child for purposes of illustrating my treatment/service and experience as a client of PEDA and a patient to their affiliate health care providers.

I am not required to sign this authorization. PEDA does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. I can request a copy of this authorization

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be mailed to media understand that I will not be entitled to any payment or other form of remuneration as a result of any use of any information and audio/video/photographic material. If I decide to sign this form, I have the right to request that audio/video recording, filming, or photographing cease at any time. I understand that information about me or my child used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state law. I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information. To do so, I must send written notice to: **Plum Egg Donor Agency LLC 9205 W. Russell Rd. Building 3, Suite 240, Las Vegas, NV 89148**. I understand that PEDDA, as well as other persons or entities, will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within PEDDA's control that have not been previously published. If not revoked/withdrawn by me, this authorization expires ten (10) years from the date that I sign it.

Intended Parent _____

Signature _____ Date _____

Intended Parent _____

Signature _____ Date _____