PHOTOGRAPHS, VIDEO RECORDINGS, AUDIO RECORDINGS, AND/OR OTHER PROTECTED HEALTH INFORMATION (USA)

AUTHORIZATION FOR RELEASE FORM

Client Name	DOB (MM/DD/YYYY)	State of Residence

I authorize Control Bionics Inc, ("Third Party") (collectively the "Parties") to take, use and/or disclose my photograph, video recording, or audio recording (collectively my "Multimedia" and/or Protected Health Information ("PHI")) as indicated below (check all that apply).

- ☐ Photographs
- ☐ Audio Recordings
- ☐ Video/film Recordings
- ☐ Health information about my medical condition or treatment; please specify the health information you authorize for release:

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I authorize the Parties to use and/or disclose my Images and/or PHI for the following purposes (check all that apply):

- ☐ To Control Bionics internet and/or intranet sites
- ☐ Control Bionics publications (such as newsletters, brochures, podcasts, blogs, and other collateral material)
- ☐ To the public media (such as television, newspapers, magazines, internet, and social media)
- ☐ For internal Control Bionics or external educational and/or professional publications, presentations, seminars, or conferences
- ☐ Other:

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I understand that members of the public and/or members of the medical community may access or view my Multimedia and/or PHI. During the recording/filming, I have the right to stop recording/filming at any time.

I understand that Control Bionics is not receiving direct or indirect compensation for the disclosure of my Multimedia or PHI for marketing purposes. I waive all rights to my Multimedia and further understand my Multimedia will become the property of Control Bionics or the Third Party. This Authorization is given without promise of compensation now or in the future for the use of my Multimedia and/or PHI.

Execution of Authorization: I understand I am not required to sign this Authorization. If I sign this Authorization, I have a right to a copy of it. Control Bionics will not condition treatment, payment, enrollment or eligibility for benefits on signing this Authorization.

Revocation of Authorization: I may revoke this Authorization at any time by providing written notice to Control Bionics Inc 745 Center Street, Suite 303 Milford OH 45150. A withdrawal of this Authorization will not apply to any of my Multimedia or other PHI already used or disclosed in reliance upon this Authorization.

Expiration: Unless otherwise revoked, this Authorization will expire on (enter specific date or event). If no date or event is indicated, this Authorization will not expire.

Release of Liability: I agree Control Bionics is hereby released from legal responsibility or liability for taking, using, or disclosing my Multimedia and/or PHI to the extent indicated in this Authorization.

Re-Disclosure: I understand once the Parties use or disclose my Multimedia and/or PHI, it may no longer be protected by privacy laws if such laws do not apply to the recipient. Control Bionics is not responsible for the recall or removal of my Multimedia and/or PHI shared by the Third Party or other entities on internet sites or in publications not affiliated with Control Bionics.

This form must be signed and dated to be valid. Mark is acceptable with witness. Please submit this completed form via email, fax, or mail to:

FUNDING@CONTROLBIONICS.COM
F: (513) 322-4678

CONTROL BIONICS
Attn: Funding
745 Center St, Suite 303
Milford OH 45150

Questions? Email funding@controlbionics.com

Signature (Patient or Legal Representative)	
Signer Name	Date (MM/DD/YYYY)
Authority of Legal Representative If Applicable	
Name of Witness If Applicable	Date (MM/DD/YYYY)

By providing your email address and/or phone number, you allow Control Bionics to contact you about participating in future marketing efforts.

Email Address	Phone Number