CONSENT FORM AND WAIVER

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION AND/OR IMAGE (PHOTOGRAPH OR VIDEOTAPE) FOR **MEDICAL PURPOSES ONLY**

I hereby give consent to Grayson Pediatric, LLC. (hereinafter "Grayson Pediatrics") to take and use images (photographs or videotape) or sounds recordings of me and/or the minor patient or person named below for whom I am giving consent, and disclose confidential patient information about me and/or the minor patient or person, to any medical facility as it pertains to the diagnoses and treatment of the minor patient or person named below form whom I am giving consent. (**Most common picture examples: rashes, birthmarks, lacerations, skin lesions, pigmentation changes, etc.)(Most common sound/video recordings: cough, breathing patterns, pitch of voice/cry of child, muscle tone, etc)**

I understand that confidential information to be disclosed may include information about the patient's treatment at Grayson Pediatrics obtained from interviews of the family, physicians and hospital personnel, or from the patient's medical records, including photographs, x-rays, videotapes and results of diagnostic studies, and I hereby waive the right to or interest in the confidentiality of this patient information or images taken and disclosed to the public, as contemplated in this release.

I hereby release and forever discharge Grayson Pediatrics (including without limitation all corporate affiliates and officers, directors, trustees, employees, medical staff members and agents) from any and all claims, liability, actions, suits, demands, costs, expenses or indebtedness arising out of, related to, or in any way connected with the use of images or disclosure of the information and materials described herein, and I hereby waive all rights and interest in ad to such information and materials.

I have been informed that once this information is disclosed it may no longer be protected by federal privacy regulations. I have been informed that this authorization is voluntary and is subject to revocation at any time, except to the extent that action has been taken in reliance thereon, by notifying Grayson Pediatrics in writing at: 297 Cooper Road Loganville, GA 30052.

Name of Minor patient or person	D.O.B. of minor patient or person	Name of consenting individual, parent or legal guardian	Relationship to minor patient or person

_____ _____
Signature of Consenting Individual, Parent or Guardian Date

_____ _____ _____ _____
Street Address City State Zip

_____ _____
Home Phone Work Phone

Grayson Pediatrics, LLC
297 Cooper Road
Loganville, GA 30052