CENTER FOR WEIGHT LOSS SURGERY
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Interview & Photography Agreement

By checking the boxes and filling in the information below, I hereby give my consent to the Center For Weight Loss Surgery (CWLS) for my image and personal information, including the information listed below and/or provided in my interview, to be used, recorded, videotaped, disclosed, displayed, published, broadcast, and/or telecast for the benefit of CWLS and/or M.S. Srikanth, M.D. This use may include, but is not limited to, publication of my photographs and information in connection with CWLS power point presentations, CWLS video presentations, CWLS Prospective Patient DVDs, television and radio interviews, CWLS' website, CWLS social media, and newspaper, magazine and other publication interviews.

Name: _____ Age: _____

Current Weight: _____ Highest Weight: _____ Approx. amount of excess weight PRIOR to surgery: _____

Name of Surgeon: _____

Type of Surgery: _____ Date of Surgery: _____

General description of my medical conditions as explained by my physician or myself in written testimony.

Area of Residence: _____

- ❑ I consent to be photographed and/or recorded by an agent of CWLS for publication
  - ❑ *And my face **may** be shown.*
  - ❑ *But my face **may not** be shown.*
- ❑ I consent to having "before surgery" and "after weight loss" pictures and/or recordings taken and published.
- ❑ I consent to be interviewed by the news media.
- ❑ I consent to be photographed and/or recorded by the news media.
- ❑ I understand that I may decline to sign this Agreement, and that failing to do so will not in any way affect the health care I will receive from CWLS.
- ❑ I understand that I am waiving my rights under the Health Insurance Portability and Accountability Act (HIPAA) and all other privacy laws.
- ❑ I understand that the photographs, recordings, interview information, and other personal information used and/or published under this Agreement may be re-disclosed and/or re-published by the news media or other recipient and such disclosure or publication cannot be controlled by CWLS.
- ❑ I understand that I will not receive any remuneration for signing this Agreement.
- ❑ I understand that I may revoke this Agreement at any time by sending a written notice specifically revoking this Agreement to Center for Weight Loss Surgery at the address on this form. I understand that if I revoke this Agreement, the revocation will not pertain to any photographs, recordings or information previously used, disclosed or published by CWLS and that revoking this Agreement will pertain only to use or publication by CWLS after the date my written revocation is received by CWLS.

I have read this form, understand its contents, and give my consent as my free and voluntary act.

_____ _____
Patient Name (print please) Patient Signature

_____ _____ _____
Email Phone Number Date