PATIENT TESTIMONIAL CONSENT AND LIKENESS RELEASE

Authorization and Consent: By signing this form (the "**Consent**"), I am authorizing, consenting to, and licensing to Healthy America LLC ("**HA,**" or the "**Company**"), a limited liability company, the rights to distribute, display, transmit, reproduce, create derivative works, broadcast, sublicense, and otherwise use and share my client testimonial about Company's services, and my image, appearance, and likeness (all collectively referred to as the "**Subject Matter**"), throughout the World and in Perpetuity. I understand and agree these uses of the Subject Matter may include, but not be limited to: posting the information on the Company website and social media pages, and displaying my testimonial on advertisements and promotions, regardless of the medium or platform (*e.g.*, TV, digital ads, internet, print, etc.). I agree I am voluntarily sharing and permitting the Company's use of the Subject Matter, without further consent from, or any royalty, payment, or other compensation to me.

PHI Waiver. I understand and agree my testimonial may include protected health information ("**PHI**") to the extent I provide PHI in my testimonial. I WAIVE ANY CLAIMS, COMPLAINTS, OR ALLEGATIONS IN REGARD TO SUCH PHI.

Right to Revoke; Limitations: I understand I have the right to revoke this Consent and any part of it at any time by providing a written request to Company's Privacy Officer at privacy@pbtelehealth.com. I understand if I choose to revoke this Consent, it will become effective on the day of the revocation of the authorization (the "**Effective Date**"), but may not be immediately processed. Company will promptly and reasonably comply with any such request. Any uses of the Subject Matter prior to the Effective Date are irrevocable and will not be subject to revocation of the Consent.

Components of Testimonial: I understand the Subject Matter may include my name, general location (not my home address), photograph, and information provided to the organization in my testimonial. I understand all other PHI Company may have access to will not be used without prior authorization. Company complies with all applicable state and federal privacy regulations, including the Health Insurance Portability and Accountability Act, Pub. L. 104-191 ("**HIPAA**").

No Requirement to Use the Subject Matter. I understand and agree Company does not have any obligation to use the Subject Matter or exercise any rights given Company by this Consent.

Additional Provisions. This Consent is my complete understanding regarding the Subject Matter and other issues contained within this Consent. It supersedes all prior and contemporaneous understandings and agreements, whether written or oral. If any term or provision of this Consent is invalid, illegal, or unenforceable in any jurisdiction, such shall not affect any other term or provision of this Consent, or invalidate or render unenforceable such term or provision in any other jurisdiction. The Company may assign this Consent and its rights within it, in whole or in part, to any third party and without notice to me. This Consent shall be binding on and shall inure to the benefit of me and the Company and our respective successors and assigns. All matters arising out of or relating to this Consent shall be governed by and construed in accordance with the internal laws of the State of Colorado. Any claim or dispute arising under this Consent may be brought only in the federal and state courts located in Denver, Colorado, and I consent to the exclusive jurisdiction of those courts.

Identification. I prefer to be identified as follows (fill in or leave blank as applicable):

_____ [FIRST NAME / INITIAL] _____ [MIDDLE NAME / INITIAL]

_____ [LAST NAME / INITIAL] _____ [INITIAL HERE TO BE ANONYMOUS]

_____ [CITY, STATE]

ATTENTION: THIS CONSENT PROVIDES COMPANY WITH YOUR CONSENT AND AUTHORIZATION TO PUBLICIZE AND COMMERCIALLY USE YOUR NAME, LIKENESS, TESTIMONIAL, AND OTHER PRIVATE INFORMATION AS SET OUT ABOVE. BY SIGNING, YOU ACKNOWLEDGE YOU HAVE READ AND UNDERSTOOD ALL OF THE TERMS OF THIS CONSENT AND AGREE WITH IT:

Signature: _____ Date: _____

If not patient, Relationship to Patient: _____

Name (Printed):_____ Date of Birth _____