YUKON-KUSKOKWIM HEALTH CORPORATION

MEDIA Authorization & Waiver of Liability

Authorization to Take & Use Photographs, Video Tapes, and/or Audio Tapes & Information

I, _____ , ("Releasor") consent to be recorded by the Yukon-Kuskokwim Health Corporation ("YKHC") and agree to the following:

In consideration of YKHC recording my image, Releasor, being of lawful age, expressly releases YKHC, its employees, directors, officers, attorneys, subsidiaries, licensees, agents, successors, assigns, personal representatives, any and all other persons, firms, corporations and the U.S. Government from all liability for claims and demands for damages for libel, slander, invasion of privacy or any other torts, lawsuits, claims and demands arising out of this agreement as set forth below.

Releasor authorizes YKHC to record his/her picture and voice on photographs, films, audio- and videotapes, and any other media whatsoever, to edit these recordings at its discretion, and to incorporate these recordings into movie and sound films or audio- and videotapes, broadcasts (radio and television, including cable and satellite transmissions) programs, or otherwise, and to use and license others to use such recordings, movie and sound film and audio- and videotapes and broadcast programs in any manner of media whatsoever, including unrestricted use for purposes of publicity, advertising and sales promotion and to use Releasor's name, likeness, voice and biographic or other information in connection herewith.

Releasor further agrees to indemnify and save harmless YKHC, its employees, directors, officers, attorneys, subsidiaries, licensees, agents, successors, assigns, personal representatives, any and all other persons, firms, corporations and the U.S. Government, from any and all claims and liability for damages, losses or expenses of any sort except for YKHC's intentional or wilfull misconduct arising from the making of such recordings and their use.

Releasor further acknowledges that there were no promises of any compensation for such use by YKHC or by anyone associated with YKHC and, that YKHC exclusively owns all rights to these recordings regardless of the form in which they are produced or used.

I understand that I may withdraw my permission at any time by informing the staff verbally or in writing. This withdrawal is valid except for those recordings already taken with my approval.

_____

Purpose of Photo or Recording

_____ _____

Signature of Patient/Patient Representative/Guardian *Date*

_____

Printed Name and Phone Number

_____ _____

Signature of Witness *Date*

_____

Witness Printed Name