Release to Vericel for Use of Content

I acknowledge, by signing below, I have read and understand this Release.

I grant to the Vericel Corporation and its consultants, successors, and/or assigns (collectively the "Company") the right and permission to use content containing myself for educational and commercial purposes (collectively the "Content"). Such content includes, but is not limited to, images, videos, quotations, audio recordings, and descriptions of the patient's condition and treatment.

I understand that the Company will use the Content (or derivative content) for any purpose in any form and on any platform, including, but not limited to, websites and social media channels, and by sales representatives during discussions with healthcare professionals.

I understand and agree that the Content may identify me. I reserve the right to review the proposed main Content.

I agree that the Content, including photographs and video rights, remain the property of Vericel.

This Release shall cover five-years from its execution or until the attached Patient HIPAA Authorization and Notice of Release of Information is revoked, whichever first occurs.

_____ _____

Signature of Individual Within Content Date

Printed Name of Individual Within Content:

_____

Patient HIPAA Authorization and Notice of Release of Information

By signing this Authorization, I authorize the release of only my protected health information included in the content related to my treatment of cartilage defects to Vericel Corporation ("Vericel") and its respective affiliates, agents and contracted third parties, and its subsidiaries and affiliates, contractors, employees, agents and successors (collectively, "Companies") as well as the information filmed by my healthcare providers.

I understand that the information within the content, which may include, but is not limited to, images, videos, quotations, audio recordings, and descriptions of my condition and treatment, may be used for commercial and education purposes as stated in the video release form (collectively the "Content").

I understand that Vericel may pay a third party to capture and create Content which will disclose only my information as described in this Authorization.

I understand that I am not required to sign this Authorization as a condition to receiving treatment with Vericel's products. I understand that I may refuse to sign this Authorization. If I sign, I will be given a copy of this Authorization after it is signed.

I understand that I may revoke this Authorization at any time by notifying Vericel in writing at the following address Vericel Corporation, 64 Sidney Street, Cambridge, MA 02139, Attention: General Counsel.

I understand that the revocation of this Authorization will be effective upon actual receipt of my letter by Vericel at the above address. Revoking this Authorization will end my consent to further disclosure of my protected health information by Vericel. If I revoke this Authorization, it will not have any effect on any actions taken by the Companies before the revocation.

This Authorization expires five years from the date this Authorization is signed (unless a shorter period is required by law).

My signature certifies that I have read this Authorization and that I authorize the use and disclosure of only my protected health information within the videos filmed.

Agreed:

Patient Signature: _____ Date: _____

Patient Name (print): _____