

(EXAMPLE) PATIENT TESTIMONIAL for {{Practice Name}}

You have experienced firsthand how effective care can be! Help us share your story by providing a short written or recorded testimonial. **Please read carefully and sign the release below.**

Say whatever you would like: _____

_____ (use back if needed)

Or, if audio/video testimonial, enter the date of audio/video recording: _____

Proposed Uses: website(s); print advertising and marketing; social media, e.g., Facebook, Twitter, Constant Contact, Instagram, etc.; verbal conversation with clients and prospective clients.

Purpose of Consent: By signing this form, you are hereby consenting to allow {{Practice Name}} to use and disclose the information in your testimonial (written or recorded) and use your photo/video (if indicated below) and acknowledge that your testimonial and your photo/video (if indicated below) may be distributed to the public.

Right to Revoke: You have the right to revoke this Release at any time by providing your revocation and submitting it, in writing, to {{Practice Name}}. Please understand that revocation of this release will not affect any action {{Practice Name}} took in reliance on this release before receiving your revocation.

CONSENT TO RELEASE

I hereby authorize {{Practice Name}} to use my testimonial, my photo/video (if indicated below), and any information contained herein in its public relations efforts. I understand and approve the disclosure of testimonial information, and my photo (if indicated below), to the media and other individuals and entities that may be involved in the public relations efforts.

I understand the information I provide in my testimonial, which I authorize {{Practice Name}} to disclose, likely reflects protected information held by {{Practice Name}}, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations. I waive the right of prior approval and hereby release {{Practice Name}} from any and all claims for damages of any kind based on the use of my testimonial, my photo/video (if indicated below), or information in the testimonial.

By signing below I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Consent to Release my Patient Testimonial.

{{Practice Name}} may use my recorded audio/video/image (select only one):

- _____ Yes, you may use my recorded audio/video/image
- _____ No, you may not use any recording or image of me

{{Practice Name}} may use my name in this following manner (select only one):

- _____ Yes, use my first name and first initial of my last name (e.g., Jeff B., Michelle H.)
- _____ Yes, use first initial of my first name and first initial of my last name (e.g., J.B., M.H.)
- _____ No, use only my written testimonial, I would like to remain "anonymous"

Signature / Guardian signature if client under 18

Date

Print Name

THANK YOU SO MUCH!!!