

2. What would you say to a friend or family member who was curious about Chiropractic Care?: _____

3. What has pleased you most in your course of treatment at our practice?

4. Additional notes/comments:

Please read and sign the Patient Testimonial Release Consent form on the following page.

Thank you!



Kaplan Chiropractic Office
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Patient Testimonial Release Consent

Purpose of Consent: By signing this form, you are hereby consenting to allow Kaplan Chiropractic Office to use and disclose the information in your testimonial and acknowledge that your testimonial may be distributed to the public.

Right to Revoke: You have the right to revoke this Release at any time by providing written notice of your revocation and submitting it to the Contact Person listed below. Please understand that revocation of this Release will not affect any action **Kaplan Chiropractic Office** took in reliance on this Release before receiving your revocation.

CONSENT TO RELEASE

I hereby authorize **Kaplan Chiropractic Office** and staff to use my testimonial and any information contained herein in its public relations efforts. I understand and approve the disclosure of testimonial information to the media and other individuals and entities that may be involved in the public relations efforts of **Kaplan Chiropractic Office**. I understand and acknowledge that the media may be interested in telling my story, and I am willing to cooperate and participate in media interviews as they arise.

I understand that I am providing the testimonial information to **Kaplan Chiropractic Office** and that my treating healthcare provider will not be providing any protected information to the media or the public, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release **Kaplan Chiropractic Office** from any and all claims for damages of any kind based on the use of my testimonial 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.

Signature

Date

Print Name

Please provide your contact information:

Address

Phone

Email