Patient Testimonial, Video, Photo, Audio Release Consent

Purpose of Consent: By signing this form, you are hereby consenting to allow ***DOCTOR AND/OR PRACTICE NAME HERE*** to use and disclose your testimonial, audio, photos and/or videos and you acknowledge that they 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 **DOCTOR AND/OR PRACTICE NAME HERE** took in reliance on this release before receiving your revocation.

CONSENT TO RELEASE

I hereby authorize **DOCTOR AND/OR PRACTICE NAME HERE** and staff to use my testimonial, photos, videos, audio and any information contained herein in its media/public relations efforts. I understand and approve the disclosure of the testimonial, photo, video, audio information to the media and other individuals and entities that may be involved in the media/public relations efforts of **DOCTOR AND/OR PRACTICE NAME HERE**.

I understand that I am providing the testimonial, photo, video, or audio information to **DOCTOR AND/OR PRACTICE NAME HERE** 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 **DOCTOR AND/OR PRACTICE NAME HERE** from any and all claims for damages of any kind based on the use of my testimonial, picture, video, audio 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 and other media I provided to the doctor.

_____ _____

Signature Date

_____

Print Name

Please provide your contact information:

Address _____

Phone _____

Email _____