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PATIENT TESTIMONIAL CONSENT RELEASE

Purpose of Consent: By signing this form, you are hereby consenting to allow Arbor Creek Chiropractic 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 Arbor Creek Chiropractic. Please understand that revocation of this Release will not affect any action Arbor Creek Chiropractic took in reliance on this Release before receiving your revocation.

CONSENT TO RELEASE

I hereby authorize Arbor Creek Chiropractic 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 Arbor Creek Chiropractic.

I understand that I am providing the testimonial information to Arbor Creek Chiropractic 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 Arbor Creek Chiropractic 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.

_____ _____

Patient's Name (Printed) Date

_____

Patient's Signature

CONSENT TO RELEASE MEDIA

OPTIONAL: (The authorization or non-authorization of photos will not affect the posting of testimonials) I hereby authorize Arbor Creek Chiropractic to use my photo(s) with my patient testimonial on their web site or in any public relations efforts that they see fit. This is including but not limited to their web site, advertising, mailers, etc. I understand that I may withdraw the use of my photo at any time by writing to: Arbor Creek Chiropractic, PO BOX 2875 Olathe, KS 66063.

Pictures and be uploaded using our convenient submission system located on our website. Click here to go directly to the testimonial and picture submission area.

_____ _____

Patient's Signature (Optional) Date