

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!



Tipp City Chiropractic Center
215 S. Garber Drive
Tipp City, OH 45371
(937) 667-7700

Brookville Chiropractic Center
582 Upper Lewisburg-Salem Rd.
Brookville, OH 45309
(937) 833-4200

Patient Testimonial Release Consent

Purpose of Consent: By signing this form, you are hereby consenting to allow Tipp City Chiropractic Center & its affiliate Brookville Chiropractic Center 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 Tipp City & Brookville Chiropractic Centers took in reliance on this Release before receiving your revocation.

CONSENT TO RELEASE

I hereby authorize Tipp City & Brookville Chiropractic Centers 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 Tipp City & Brookville Chiropractic Centers. 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 Tipp City/Brookville Chiropractic Centers 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 Tipp City & Brookville Chiropractic Centers 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



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PHOTO RELEASE CONSENT

Purpose of Consent: By signing this form, you are consenting to allow Tipp City & Brookville Chiropractic Centers and any associated staff members to use and distribute your photo along with your patient testimonial.

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 us. Please understand that revocation of this Release will not affect any action Tipp City & Brookville Chiropractic Centers or his/her staff took in reliance on this Release before receiving your revocation.

I hereby grant permission to allow Tipp City & Brookville Chiropractic Centers to use the photograph of me shown below in conjunction with my patient testimonial. I hereby agree and acknowledge that my photo will be released to the public via public relation efforts of Tipp City & Brookville Chiropractic Centers. I further acknowledge and agree that my photo may be used by the media.

I waive the right of prior approval and hereby release Tipp City & Brookville Chiropractic Centers from any and all claims for damages of any kind based on the use of my photo or information contained in my 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 Release.

Signature

Date

Print Name



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Video Patient Testimonial Release Consent

Purpose of Consent: By signing this form, you are hereby consenting to allow Tipp City & Brookville Chiropractic Centers to use and disclose the information you provided in your video patient 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 Tipp City & Brookville Chiropractic Centers took in reliance on this Release before receiving your revocation.

CONSENT TO RELEASE

I hereby authorize Tipp City & Brookville Chiropractic Centers and staff to use my video 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 Tipp City & Brookville Chiropractic Centers. 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 should the need arise.

I understand that I am providing the video testimonial information to Tipp City & Brookville Chiropractic Centers 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 Tipp City & Brookville Chiropractic Centers from any and all claims for damages of any kind based on the use of my video testimonial or information provided within the video 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 Video Patient Testimonial.

Signature

Date

Print Name

Please provide your contact information:

Address

Phone

Email