RELEASE FORM

Allowable contact by Email /Text /Phone
Use of Testimonial (Written/Video/Photo)

Being a Health Care Provider, one of our top priorities is to protect you and your private health information (PHI).
We go to great lengths to ensure that your PHI is well protected.

As well, at Advanced Chiropractic Associates, PLLC, we are passionate about clear communication and transparency. By supplying education, to help support your needs, as well as educate your family, friends and neighbors regarding healthy lifestyle changes and our services, everybody wins! This information causes us all to work harder at being healthy, helps us make better life decisions, and builds healthier communities.

As you know, we live in an ever increasingly technological age that exchanges information via cell phones, social media and internet-based activity. We have all made changes in how we connect and communicate. This advanced ability to communicate has created wonderful opportunities to create a global community, but also opens possibilities for misuse of these options. We want to communicate with you in a way that is convenient and comfortable for YOU! Please let us know you preferences below:

Authorization for Release of Information

We are requesting your permission for (office/doctor name)_____ to communicate with you in the following ways:

1) **I authorize Advanced Chiropractic Associates, PLLC to call/fax and/or leave voice or text messages, that may contain appointment reminders and/or personal information- including private health information- as well as announcements regarding product/service information, education events, seminars, etc. -at the following phone number/numbers ;**
   _____, _____,_____.
   _____ Initial here for your consent

2) **I authorize Advanced Chiropractic Associates, PLLC to utilize the following email addresses to send messages that may contain appointment reminders and/or personal information- including private health information- as well as announcements regarding product/service information, education events, seminars, etc.;**
   Email addresses: _____, _____,_____.
   _____ Initial here for your consent

TESTIMONIALS

3) **I choose to give a patient testimonial** for the purpose of, but not limited to, the publication or promotion of my thoughts, feelings, and experiences, as they relate to Advanced Chiropractic Associates, PLLC, Dr. Parson and /or staff.

   I understand my testimonial/review, made on behalf of Advanced Chiropractic Associates, PLLC, may be used in connection with publicizing and promoting Advanced Chiropractic Associates, PLLC. I authorize Advanced Chiropractic Associates, PLLC to use my name, brief biographical information, and the Testimonial/Review, as well as any photographs of me. The effective date is the first day of any services provided by Advanced Chiropractic Associates, PLLC, Dr Parson, and /or staff.

   I hereby irrevocably authorize Advanced Chiropractic Associates, PLLC to copy, exhibit, publish or distribute pictures, video and/or my written Testimonial/Review for purposes of publicizing Advanced Chiropractic Associates, PLLC programs or for any other lawful purpose. These statements, photos or videos may be used in printed publications, multimedia presentations, on websites or in any other distribution media. I agree that I will make no monetary or other claim against Advanced Chiropractic Associates, PLLC for the use of the statement, testimonials/reviews, video or pictorial representations of me. In addition, I waive any right to inspect or approve the finished product, including written copy or edited video wherein my likeness or my testimonial appears. I hereby hold harmless and release Advanced Chiropractic Associates, PLLC from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons, acting on my behalf or on behalf of my estate, have or may have by reason of this authorization.
   _____ Initial here for your consent

I have read the information above and authorize the initialed sections.

Signature: _____

Printed Name: _____

Email: _____

Address: _____

City, State, Zip: _____

Cell phone: _____ Date: _____