

Patient Video Testimonial Release Form

Date _____

Authorization and Release of Testimonial Information

I understand my video testimonial (the "Testimonial") made on behalf of [Practice Name] (hereinafter called "The Practice") may be used in connection with publicizing and promoting The Practice. I authorize The Practice to use my name, brief biographical information, and the Testimonial as defined on this form.

I hereby irrevocably authorize The Practice to copy, exhibit, publish or distribute the Testimonial for purposes of publicizing The Practice's services or for any other lawful purpose. These statements 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 The Practice for the use of the statement.

In addition, I waive any right to inspect or approve the finished product, including written copy, wherein my testimonial appears.

I hereby hold harmless and release The Practice 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.

Signature: _____

I have read the authorization and release information and give my consent for the use of my testimonial as indicated above.

Printed Name: _____

Signature: _____

Email: _____

Address: _____

City, State, Zip: _____