PATIENT TESTIMONIAL for WINTHROP EYE CENTER

You have experienced firsthand how effective care can be! Help us share your story by providing a short written or recorded testimonial. ***Please read carefully and sign the release below***.

Say whatever you would like: _____

_____

_____

_____ (use back if needed)

Or, enter the date of audio/video recording or photo: _____

Proposed Uses: website(s); print advertising and marketing; social media, e.g., Facebook, Twitter, Instagram, etc.; verbal conversation with clients and prospective clients.

Purpose of Consent: By signing this form, you are hereby consenting to allow Winthrop Eye Center to use and disclose the information in your testimonial (written or recorded) and use your photo/video (if indicated below) and acknowledge that your testimonial and your photo/video (if indicated below) may be distributed to the public.

Right to Revoke: You have the right to revoke this Release at any time by providing your revocation and submitting it, in writing, to Winthrop Eye Center. Please understand that revocation of this release will not affect any action Winthrop Eye Center took in reliance on this release before receiving your revocation.

CONSENT TO RELEASE

I hereby authorize Winthrop Eye Center to use my testimonial, my photo/video (if indicated below), and any information contained herein in its public relations efforts. I understand and approve the disclosure of testimonial information, and my photo (if indicated below), to the media and other individuals and entities that may be involved in the public relations efforts.

I understand the information I provide in my testimonial, which I authorize Winthrop Eye Center to disclose, likely reflects protected information held by Winthrop Eye Center, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations. I waive the right of prior approval and hereby release Winthrop Eye Center from any and all claims for damages of any kind based on the use of my testimonial, my photo/video (if indicated below), 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.

Winthrop Eye Center may use my recorded audio/video/image (select only one):

_____ Yes, you may use my recorded audio/video/image

_____ No, you may not use any recording or image of me

Winthrop Eye Center may use my name in this following manner (select only one):

_____ Yes, use my first name and first initial of my last name (e.g., Jeff B., Michelle H.)

_____ Yes, use first initial of my first name and first initial of my last name (e.g., J.B., M.H.)

_____ No, use only my written testimonial, I would like to remain “anonymous”

_____ _____

Signature / Guardian signature if client under 18 Date

_____

Print Name

THANK YOU FOR SUPPORTING OUR BUSINESS!