Patient Testimonial Release Consent

Purpose of Consent: By signing this form, you are consenting to Ord Sports Chiropractic and Wellness, LLC (OSCW) use and disclosure of the information in your testimonial and acknowledgement that the testimonial may be distributed to the public.

Right to Revoke: You have the right to revoke this Release at any time by giving us a 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 OSCW took in reliance on this Release before receiving your revocation.

CONSENT TO RELEASE

I hereby authorize OSCW to use my testimonial and any information in the testimonial in its public relations efforts. I understand and approve the disclosure by OSCW of testimonial information to the media and other individuals and entities that may be involved in OSCW's public relations efforts. I acknowledge that the media may be interested in my story, and I am willing to participate in media interviews as they arise.

I understand that I am providing the testimonial information to OSCW and that my treating physician will not be providing any information to OSCW, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including, Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release OSCW from all claims for damages of any kind based on the use of my testimonial or information in the testimonial.

I am of legal age and freely sign this release, which I have read and understood.

_____

Signature

_____

Print Name

_____/_____/_____

Date

Please provide your contact information.

_____

Name

_____

Address

_____

City, State, and ZIP Code

_____

E-mail

Phone: (_____) _____ - _____