Testimonial Release Form - Client (Name Disclosed)

[COMPANYLOGO]

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Your Clinician (hereafter, “Provider”) is requesting your written review of Provider’s services (hereafter, “Testimonial”) for Provider’s advertising and marketing use.

If you agree to provide a Testimonial, please complete Sections A and B below, as well as the Health Insurance Portability and Accountability Act ("HIPAA") Authorization that follows.

Note: In consideration of your privacy and rights under HIPAA, Provider cannot use your Testimonial, your name, or any other protected health information you disclose on this form unless you complete the HIPAA Authorization.

Section A - Basic Information

Your Name

First: *

Last: *

Your Provider

First Name: *

Last Name: *

Relationship to Provider: *

☐ I have received counseling, physical therapy, occupational therapy or other mental health and wellness services from Provider

Acknowledgement of Business Relationship: *

☐ I am a paying client of Provider and will provide my review based on services I have received at Provider’s established rate

☐ I will refrain from commenting on services I have received on a complimentary or discounted basis unless I have received those services through Medicaid, Medicare or another government sponsored health program

Name Disclosure Preference - Disclosed *

☐ I give Provider permission to post my first name and the first initial of my last name next to my Testimonial on Provider's website and to use this information elsewhere for marketing purposes

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Section B - Testimonial

Please write your Testimonial below: *

Please try to keep your Testimonial to 50 words or fewer. If your Testimonial is longer, note that Provider may not publish it in its entirety.

HIPAA AUTHORIZATION - USE/DISCLOSURE OF NAME AND PROTECTED HEALTH INFORMATION FOR PROVIDER MARKETING USE

To ensure Provider is acting in accordance with your wishes and using your Testimonial with your authorization, please complete and sign this form. Provider will mail or email you a copy of this signed form and will keep a copy of your signed permission on file.

Contact Information

Your Name: *

Your Address: *

Your Email: *

Provider seeks your consent to reproduce and distribute your Testimonial(s) containing your Protected Health Information for Provider's marketing purposes, including but not limited to use in Provider's advertisements and commercials, social media campaigns, medical and general interest publications and medical and patient education information, in all media (including internet/online, TV, radio, newspapers, and magazines) throughout the world (collectively "Provider Marketing Use").

Please read each authorization below carefully and initial all that apply.

I give my permission for Provider and others authorized by Provider to use, release, reproduce, and distribute my name or initials and any written statements I provided in Section B of this form (my Testimonial). This includes information about my medical condition, diagnoses, medical care, and/or health coverage if I have included such information in my Testimonial.

Tick if you agree *

- [ ] Yes, i agree

I specifically authorize the release of information pertaining to mental health diagnosis or treatment. (If applicable) *

- ◯ Yes, I agree
- ◯ Not applicable

I specifically authorize the release of information pertaining to HIV/AIDS test results. (If applicable)

- ◯ Yes, I agree
- ◯ Not applicable

I understand I am not required to sign this authorization. Provider does not condition treatment, payment, benefit eligibility, or enrollment activities on whether or not I agree to sign this form. I can request that a copy of this authorization be mailed to me. I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of my name, initials and Testimonial.

I am aware that any Protected Health Information I have disclosed about myself in my Testimonial will exist forever in either a recorded, printed, and/or electronic version or other version as may develop over time, and that once it is published or disclosed in any form it will continue to be used. I understand that information about me used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state law.

If I decide to sign this form, I understand I have the right to revoke or withdraw my permission at any time to prohibit future use of my information. To do so, I must send written notice to Provider at Provider's physical address or to Provider's email address.

I understand that Provider, as well as other persons or entities, will retain copies of any such electronic or printed versions and may retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within Provider's control that have not been previously published.

If not revoked/withdrawn by me, this authorization expires ten (10) years from the date that I sign it.

Electronic Signatures Notice

If you or your legal representative choose to provide an electronic signature on this form, the electronic signature must be sufficient to result in a legally binding contract under applicable State and other law. Please confirm with your Provider that your signature will meet these requirements before signing this form.

Client or Legal Representative/Parent Signature *

☐ By checking this, you are eSigning this form

Your Name

First: *

Last: *

If a personal representative signs this form, that representative warrants that they have also completed a HIPAA Personal Representative Form and hereby represents that they have authority to sign this form on the basis of:

Today\'s Date: *