Patient Testimonial Release Authorization Form

Purpose of Authorization
By signing this authorization form, I am authorizing Go To Ortho & Summit Orthopaedics to distribute and share my patient testimonial. Sharing my patient testimonial may include posting the information on the company website, posting the testimonial information on Go To Ortho & Summit Orthopaedics' social media pages, and including my testimonial on advertisements and promotions, including but not limited to print advertising and television commercials. I agree that I am voluntarily sharing my testimonial about services from Go To Ortho & Summit Orthopaedics, and I am receiving no financial remuneration from Go To Ortho & Summit Orthopaedics for providing my testimonial and allowing them to use my protected health information for marketing purposes.

Right to Revoke
I understand that I have the right to revoke this authorization at any time by providing a written request to the Privacy Officer at Go To Ortho & Summit Orthopaedics. I understand that if I choose to revoke this authorization, it will become effective on the day of the revocation of the authorization. Any prior uses and disclosures of my testimonial with my protected health information will not be subject to the revocation of the authorization. I understand that Go To Ortho & Summit Orthopaedics will make its best effort to remove my testimonial and protected health information from any marketing platform controlled by Go To Ortho & Summit Orthopaedics. Likewise, I understand that Go To Ortho & Summit Orthopaedics does not have control over outside vendors who may distribute my testimonial prior to any revocation.

Components of my Testimonial
I understand that my patient testimonial for Go To Ortho & Summit Orthopaedics will only include my name, location, photograph and/or video, and information provided to the organization in my testimonial. I understand that all other protected health information that Go To Ortho & Summit Orthopaedics creates and maintains for purposes of my care will not be used in my testimonial or for marketing purposes without prior authorization per privacy regulations of the state and Health Insurance Portability and Accountability Act (HIPAA).

By signing below, I agree and acknowledge that I have read and understood all of the elements of this authorization for use of my patient testimonial.

Signature: _____

Date: _____

Name of Patient (Printed):_____

Patient Date of Birth:_____

If not patient, what is your relationship to the patient? _____

Are you authorized to sign for the patient? Yes/No (circle one)

Name of Authorized Signer (Printed):_____