Patient Testimonial Release Authorization Form

Purpose of Authorization

By signing this authorization form, I am authorizing Summit Orthopaedics, Go To Ortho, and its associated physicians, staff and any future assigns (collectively, "Summit") to collect and distribute my patient testimonial. Sharing my patient testimonial may include posting the information on the company website, posting the testimonial information on Summit's social media pages, and including my testimonial on advertisements and promotions, including but not limited to print advertising, television commercials and potentially any technology known or yet to be developed. I agree that I am voluntarily sharing my testimonial about services from Summit, and I am receiving no financial remuneration from Summit 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 Summit. 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 information will not be subject to the revocation of the authorization. I understand that Summit will make its best effort to remove my testimonial and protected health information from any marketing platform controlled by Summit. Likewise, I understand that Summit does not have control over what happens to content once it is placed online prior to any revocation.

Components of My Testimonial

I understand that my patient testimonial for Summit will include my written testimonial, photograph, video, and relevant medical history including, but not limited to my age, gender, medical condition, procedures, and radiographs from before, during, or after surgery. Additionally, I hereby authorize the release of the following marked information (check one).

☐ First and Last Name

☐ First Name Only

☐ I would like my name to remain Anonymous.

☐ I would like to use the following Pseudonym: _____

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

Signature: _____ **Date:** _____

Name of Patient (Printed): _____ **Patient Date of Birth:** _____