CORE
ORTHOPEDICS & SPORTS MEDICINE

Client/Patient Testimonial Release Authorization Form

Purpose of Authorization: By signing this authorization form, I am providing CORE Orthopedic and Sports Medicine to distribute and share my client testimonial that I provided. Sharing my client testimonial may include posting the information on the company website, posting the testimonial information on CORE Orthopedic and Sports Medicine's social media pages, and including my testimonial on printed advertisements and promotions. I agree that I am voluntarily sharing my testimonial about services from CORE Orthopedic and Sports Medicine, and I am receiving no financial remuneration from CORE Orthopedic and Sports Medicine 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 CORE Orthopedic and Sports Medicine. 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 CORE Orthopedic and Sports Medicine will make it best effort to remove my testimonial and protected health information from the CORE Orthopedic and Sports Medicine's website and other social media pages.

Components of my Testimonial: I understand that the client testimonial for CORE Orthopedic and Sports Medicinewill only include my name, location, photograph, and information provided to the organization in my testimonial. I understand that all other protected health information that CORE Orthopedic and Sports Medicine 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 client testimonial. This authorization will expire 12 months after the date of the signature. After the expiration, I understand that CORE Orthopedic and Sports Medicine will not be allowed to use my testimonial for any future marketing purposes. It does not require CORE Orthopedic and Sports Medicine to remove my testimonial from the website or other social media pages unless I specifically request a revocation of this authorization.

I prefer to be identified in the following way for my client testimonial:

- ☐ My full first and last name (Sally Sample, City, State)
- ☐ My first name and last initial only (Sally S., City, State)
- ☐ My first and last initial only (S. S., City, State)
- ☐ Please leave my identity anonymous (Anonymous, City, State)

☐ Please leave my location off of my client testimonial

☐ Other_____

Signature: _____ Date: _____

If not patient, Relationship to Patient: _____

Name (Printed):_____ Date of Birth _____`