CHIROsport & Spine, LLC
Dr. Brian L. Baldia, DC
421 E. Main Street
Endicott, NY 13760
Phone: (607) 321-7674 Fax: (607) 239-6772
http://www.chirosportandspine.com

SHARE YOUR CHIROPRACTIC STORY!

You've been a Chiropractic patient and you've seen first hand how effective it can be! Help us share your story with the world! Has Chiropractic relieved your pain and given you back the ability to enjoy life? Has it helped you avoid surgery? Has Chiropractic changed your world and improved your life? Whatever your testimonial, don't keep it to yourself!

Fill out the short questionnaire below (feel free to use the back or a separate sheet of paper if you need more room). When you are finished, please read and sign the release on the next page to give us permission to use your testimonial. Then simply turn the testimonial in, or send it to us using the contact information above. We might just share your story with other patients, or even the media! We love to hear how we have helped improve the health, wellness and quality of life of our patients with Chiropractic care. Your testimonial could help improve the lives of others by showing how Chiropractic has positively impacted your life.

1. How has Chiropractic care improved your life?:

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2. **What would you say to a friend or family member who was curious about Chiropractic Care?:**____
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3. **What has pleased you most in your course of treatment at our practice?**
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4. **Additional notes/comments:**

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Please read and sign the Patient Testimonial Release Consent form on the following page.

Thank you!

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Patient Testimonial Release Consent

Purpose of Consent: By signing this form, you are hereby consenting to allow ***CHIROSPORT & SPINE***, to use and disclose the information in your testimonial and acknowledge that your testimonial may be distributed to the public.

Right to Revoke: You have the right to revoke this Release at any time by providing 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 **CHIROsport & Spine, LLC** took in reliance on this Release before receiving your revocation.

CONSENT TO RELEASE

I hereby authorize **CHIROsport & Spine, LLC** and staff to use my testimonial and any information contained herein in its public relations efforts. I understand and approve the disclosure of testimonial information to the media and other individuals and entities that may be involved in the public relations efforts of **CHIROsport & Spine, LLC** I understand and acknowledge that the media may be interested in telling my story, and I am willing to cooperate and participate in media interviews as they arise.

I understand that I am providing the testimonial information to **CHIROsport & Spine, LLC** and that my treating healthcare provider will not be providing any protected information to the media or the public, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release **CHIROsport & Spine, LLC** from any and all claims for damages of any kind based on the use of my testimonial or information in the testimonial. By signing below, I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Consent to Release my Patient Testimonial.

____
Signature Date

____
Print Name

Please provide your contact information:

____
Address

____
Phone Email

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PHOTO RELEASE CONSENT

Purpose of Consent: By signing this form, you are consenting to allow **CHIROsport & Spine, LLC** and any associated staff members to use and distribute your photo along with your patient testimonial.

Right to Revoke: You have the right to revoke this Release at any time by providing written notice of your revocation and submitting it to us. Please understand that revocation of this Release will not affect any action **CHIROsport & Spine, LLC** or his/her staff took in reliance on this Release before receiving your revocation.

I hereby grant permission to allow **CHIROsport & Spine, LLC** to use the photograph of me shown below in conjunction with my patient testimonial. I hereby agree and acknowledge that my photo will be released to the public via public relation efforts of **CHIROsport & Spine, LLC** I further acknowledge and agree that my photo may be used by the media.

I waive the right of prior approval and hereby release **CHIROsport & Spine, LLC** from any and all claims for damages of any kind based on the use of my photo or information contained in my testimonial.

By signing below I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Release.

____
Signature Date

____
Print Name

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Video Patient Testimonial Release Consent

Purpose of Consent: By signing this form, you are hereby consenting to **CHIROsport & Spine, LLC** to use and disclose the information you provided in your video patient testimonial and acknowledge that your testimonial may be distributed to the public.

Right to Revoke: You have the right to revoke this Release at any time by providing 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 **CHIROsport & Spine, LLC** took in reliance on this Release before receiving your revocation.

CONSENT TO RELEASE

I hereby authorize **CHIROsport & Spine, LLC** and staff to use my video testimonial and any information contained herein in its public relations efforts. I understand and approve the disclosure of testimonial information to the media and other individuals and entities that may be involved in the public relations efforts of **CHIROsport & Spine, LLC** . I understand and acknowledge that the media may be interested in telling my story, and I am willing to cooperate and participate in media interviews should the need arise.

I understand that I am providing the video testimonial information **CHIROsport & Spine, LLC** and that my treating healthcare provider will not be providing any protected information to the media or the public, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release **CHIROsport & Spine, LLC** from any and all claims for damages of any kind based on the use of my video testimonial or information provided within the video testimonial. By signing below I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Consent to Release my Video Patient Testimonial.

____
Signature Date

____
Print Name

Please provide your contact information:

____
Address

____
Phone Email