GOROSPE HEALTH
WELLNESS SOLUTIONS FOR EVERYONE

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# SHARE YOUR SUCCESS STORY!

As a ***Gorospe Health*** patient, you've experienced firsthand how effective wellness care can be. Help us share your story. Has our work with you improved your health, vitality, and given you back the ability to enjoy life? Has it helped you feel better? Have our services changed your world and improved your life? Whatever your testimonial, don't keep it to yourself!

Share your story with us by answering the questions below. Please read and sign the release on the next page to give us permission to share your testimonial. Then, drop it by our office or mail it to us at the address above. We love to hear how we have helped improve the health, wellness, and quality of life of our patients with our practice's care.

Your testimonial could help improve the lives of others by showing how your care has positively impacted your life.

**How has the care you've received at Gorospe Health improved your life?**

**How long after your initial visit did you begin to see results from our wellness care?**

**What would you say to a friend or family member who is curious about wellness care?**

**What has pleased you most in the course of your treatment at our practice?**

**Do you have any words of encouragement for others?**

**Additional comments you would like to share about Gorospe Health, or the care you've received from Dr. Gorospe:**

# PATIENT TESTIMONIAL RELEASE CONSENT

*Purpose of this Release Consent*: By signing this agreement, you are consenting to allow ***Gorospe Health*** to use and disclose the information in your testimonial via various marketing activities, including web site, social media, email, print, and other marketing placements. If, at any time, you would like to remove your testimonial from future use, you may do so by contacting ***Gorospe Health.***

I hereby authorize ***Gorospe Health,*** its assignees, licensees, and successors, to use my image, testimony, and any additional information provided, in any of its marketing activities – including as modified or composite representations. I understand and approve the disclosure of testimonial information to the media, as well as other individuals and entities that may be involved, for the public relations purposes of ***Gorospe Health***.

I understand that I am providing the testimonial information to ***Gorospe Health*** 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 ***Gorospe Health*** from any and all claims for damages of any kind based on the use of my testimony, or other information as noted above. 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 Consent.

**Signature** **Date**

**Printed Name**

**Address**

**City/State/Zip**

**Phone**

**Email Address**