Patient Referral and Testimonial Release Form

This form is designed to document patient referrals and obtain consent to share your positive experiences with others. Please fill out the sections below.

1. Patient Information

Full Name:

Date of Birth:

Phone Number:

Email Address:

2. Patient Referral Information

Who referred you to our practice? (Name):

Would you like to refer someone to us? (Name of Friend/Family):

Referral Contact Phone or Email:

3. Testimonial

Please share your experience with our practice (for printing, you may write on the lines below):

4. Testimonial Release Authorization

I hereby grant permission to this practice to use my testimonial, name, and/or non-identifying biographical information in promotional materials, including but not limited to the practice website, social media, and printed brochures.

I understand that my medical records and protected health information (PHI) will remain confidential and will not be disclosed beyond what is written in my testimonial above.

Do you consent to the use of your first name only? (Type Yes or No):

Do you consent to the use of your full name? (Type Yes or No):

Patient Signature (Sign on the line below):

Date Signed: