



Testimonial Permission Form

Dear Multi-Specialty HealthCare Patient,
Thank you for sharing your feedback on your Multi-Specialty HealthCare experience. Please clearly write your testimonial and check the appropriate lines below.

Testimonial:

Your Name: _____

E-mail: _____

Multi-Specialty HealthCare Location(s) Visited: _____

Physician(s) and/or Specialist(s) Seen: _____

Referring Attorney: _____

May we use this testimonial on our website and/or marketing material? **Yes** _____ **No** _____

May we include your personal information with your testimonial in our marketing?

Check the appropriate line.

_____ **You may use my full name**

_____ **You may use my first name only**

_____ **You may use my initials**

_____ **Do not include my personal information**

Signature: _____ **Date:** _____