Patient Testimonial Release Authorization Form

Purpose of Authorization: By signing this authorization form, I am providing Roots of Wellness 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 Roots of Wellness' social media pages, and including my testimonial on printed advertisements and promotions. I agree that I am voluntarily sharing my testimonial about services from Roots of Wellness, and I am receiving no financial remuneration from Roots of Wellness 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 Roots of Wellness. 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 Roots of Wellness will make it best effort to remove my testimonial and protected health information from the Roots of Wellness' website and other social media pages.

Components of my Testimonial: I understand that the client testimonial for Roots of Wellness will only include my name, location, photograph, and information provided to the organization in my testimonial. I understand that all other protected health information that Roots of Wellness 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 Roots of Wellness will not be allowed to use my testimonial for any future marketing purposes. It does not require Roots of Wellness 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 _____

680 East Meeting Street, Suite E, Dandridge, TN 37725

Bruce K. Roff, DACM, LAc	License: 0000000326	NPI: 1538415286	rootsofwellness.health	P: 865.973.7202	F: 855.691.8540
Patient Name:				Au:	Dx:

Testimonial Questionnaire

1. What's your name, job title, and company name? If retired, from what?
2. What was your condition that you were experiencing before you received acupuncture?
3. Did you previously try anything else to relieve your condition? If so, what?
4. What hesitation or obstacles did you have that would have prevented you from receiving acupuncture treatments from Mr. Roff.
5. How were these obstacles or hesitations put to ease for you?
6. What results did you get from receiving acupuncture treatments from Mr. Roff?
7. What did you like most about your treatments?
8. What are three other benefits to receiving acupuncture treatments from Mr. Roff?
9. What would you say to anyone considering acupuncture treatments? Would you recommend Mr. Roff's services? If so, why?
10. Is there anything you would like to add?
11. Would you be willing to do a youtube video, testimonial with Mr. Roff?

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