



Phone: 254.878.4040

Fax: 469.673.2866

## Testimonial Release

Date \_\_\_\_\_

We would love to hear your feedback. Please take a moment to share a few sentences about your experience at Waco Hearing Center.

Testimonial Statement

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### AUTHORIZATION AND RELEASE INFORMATION

I understand my testimonial, as outlined above (the "Testimonial") and made on behalf of Waco Hearing Center (hereinafter called "the Clinic"), may be used in connection with publicizing and promoting the Clinic. I authorize the Clinic to use my initials (full name will never be disclosed), brief biographical information, and the Testimonial as defined on this form. I authorize the Clinic to photograph and interview me for the purposes of promoting their services. I understand my name and identity may be used for internal and external marketing purposes, as they relate to my involvement with the Clinic.

I hereby irrevocably authorize the Clinic to copy, exhibit, publish or distribute the Testimonial for purposes of publicizing the Clinic's programs or for any other lawful purpose. These statements may be used in printed publications, multimedia presentations, on websites or in any other distribution media. I agree that I will make no monetary or other claim against the Clinic for the use of the statement.

In addition, I waive any right to inspect or approve the finished product, including a written copy, wherein my likeness or my Testimonial appears.

I hereby hold harmless and release the Clinic from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I have read the authorization and release information and give my consent for the use as indicated above.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Email \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Date \_\_\_\_\_

**Thank you! We appreciate the opportunity to be of assistance to you and your family.**