

Patient Testimonial Release Consent

I hereby authorize my chiropractor, Dr. _____, to provide my testimonial to the Nova Scotia Association of Chiropractors, doing business as Chiropractors Nova Scotia (“CNS”), for use in CNS’s media and public relations efforts, including but not limited to use on the CNS website and disclosure to the media and public.

I hereby authorize CNS to use my testimonial for use in its media and public relations efforts. I understand that this may include, but is not limited to, publication of my testimonial on the CNS website, as well as disclosure by CNS directly to the media and the public.

I understand that CNS will only publish my first name and first initial of my last name and will not disclose the identity of my treating healthcare provider or specific clinic name.

I understand that my chiropractor does not have permission to provide my patient chart or any private health information contained in my medical records, other than what I have chosen to include in my testimonial, to CNS. I understand CNS will only have access to the testimonial that I have provided.

I understand that I have the right to revoke the consent I am providing to CNS to use my testimonial by providing written notice of my revocation via email to info@chirons.ca.

I hereby release CNS from all claims, damages, costs or other causes of action which may exist, now or hereafter, arising from CNS’s use of my testimonial as described herein.

By signing below, I agree and acknowledge that I have read and understood the terms of this Patient Testimonial Consent Release and agree to all terms described. I am of legal age in the Province of Nova Scotia, and freely sign this Patient Testimonial Consent Release.

Signed and delivered at _____, Nova Scotia on _____, 202__.

In the presence of:

Witness signature

Patient Signature

Witness name

Patient Name