PATIENT REVIEW / TESTIMONIAL
CONSENT & AUTHORIZATION

CONSENT TO USE PATIENT REVIEW / TESTIMONIAL

I voluntarily provide the following review, testimonial, statement, or feedback regarding my experience with **Elite Health Collective, LLC** and authorize the practice to use and publish my review for informational, educational, and practice-marketing purposes.

I understand that my review may be published on the practice's website, social media pages, online review platforms, printed materials, advertisements, or other practice communications.

I understand that my review may contain information concerning my experience receiving physical therapy services and may constitute Protected Health Information (PHI) when combined with my identity or other identifying information. I authorize **Elite Health Collective, LLC** to use and disclose the information contained in my review for the purposes described above.

I UNDERSTAND THAT:

1. My participation is voluntary, and I may choose not to provide a review.

2. My decision to provide or decline a review will not affect my eligibility for treatment, the quality of care I receive, my Medicare benefits, or my relationship with the practice.

3. I will not receive payment or other compensation for providing this review unless specifically stated in writing.

4. The review represents my personal experience and opinions and does not guarantee that other patients will experience the same or similar results.

5. Individual results vary, and the practice does not guarantee any particular treatment outcome.

6. I authorize the practice to use my review as submitted, including minor corrections for spelling, grammar, formatting, or length, provided that such edits do not materially change the meaning of my statement.

7. If I authorize identification, the practice may identify me by the name and/or other identifying information specifically selected below.

8. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy protections.

REVOCATION

I understand that I may revoke this authorization in writing at any time by contacting Tom Williams at tomwilliams@elitehco.com. I understand that revocation will not apply to information already used or disclosed in reliance on this authorization before the practice received my written revocation.

EXPIRATION

This authorization will remain in effect unless revoked in writing.

By signing below, I confirm that I have read and understand this authorization and voluntarily consent to the use and disclosure described above.

PATIENT INFORMATION

Name:	_____
Signature:	_____
	_____

Description of Review/Testimonial:	

PERMISSION FOR IDENTIFICATION

☐ I authorize the practice to publish my review without identifying my name or other identifying information.

☐ I authorize the practice to identify me by my first name and last initial.

☐ I authorize the practice to identify me by my full name.

☐ I authorize the practice to use my photograph with my review.

☐ I do not authorize the use of my photograph.

PRACTICE USE

Practice Name:	
Authorized Representative:	
Date Received:	