



Client Testimonial Authorization

Authorization:

I voluntarily authorize Respiras, LLC to use my written testimonial and/or photograph and/or video recording (if applicable) for the Respiras website and marketing.

I authorize Respiras to identify me by:

- First name only
- First name and last initial
- Initials only

I understand that:

- Participation is completely voluntary.
- My testimonial reflects my personal experience and does not guarantee similar outcomes for others.
- I will not receive compensation for my testimonial.
- My decision to provide or decline a testimonial will not affect the services I receive from Respiras, LLC.

Revocability:

I understand that I have the right to revoke this authorization at any time, but such revocation must be in writing. Materials already published before revocation may not be able to be withdrawn.

Components of my Testimonial:

I understand that Respiras will not use or disclose protected health information beyond what I voluntarily authorize through this testimonial without additional written authorization as required by applicable privacy laws and the Health Insurance Portability and Accountability Act (HIPAA).

Patient Name: _____ **Signature:** _____

Date: _____

If Personal Representative:

Name: _____

Date: _____

Signature: _____

Relationship to the patient: _____

If Patient is a Minor:

Parent/Legal Guardian: _____

Date: _____

Signature: _____