NEW JERSEY UROLOGY
Excellence In Care

Client/Patient Testimonial Release Authorization Form

Purpose of Authorization: By signing this authorization form, I am authorizing New Jersey Urology, LLC (NJU), to distribute and share the client testimonial I provided. Sharing my client testimonial may include posting the information on the company website, posting the testimonial information on NJU's social media channels, and including my testimonial in any medium for educational, promotional, advertising, or other purposes that support the mission of NJU. I agree I am voluntarily sharing my testimonial about services from NJU and that I am not required to sign this authorization. NJU does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. I can request a copy of this authorization be mailed to me. I am receiving no financial remuneration from NJU for providing my testimonial and allowing them to use my protected health information for marketing purposes.

Right to Revoke: I have the right to revoke this authorization at any time by providing a written request to the Privacy Officer at NJU. I understand that if I choose to revoke this authorization, it will become effective on the day I revoke the authorization in writing. 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 NJU, will make its best effort to remove my testimonial and protected health information from NJU's website and other social media pages.

Components of my Testimonial: I understand that the client testimonial for NJU will only include my name, location, photograph, video and voice recording, and information provided to the organization in my testimonial. I understand that all other protected health information NJU creates and maintains for purposes of my care will not be used in my testimonial or for marketing purposes without my 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 NJU will not be allowed to use my testimonial for any future marketing purposes. It does not require NJU 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 _____

Patient Signature: _____ Date: _____

If not patient, Relationship to Patient: _____

Name (Printed):_____ Date of Birth _____