



Email: dragonslifesystems@yahoo.com • Website: www.dragonslife.com

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## PATIENT TESTIMONIAL RELEASE CONSENT

**Purpose of Consent:** By signing this form, you are hereby consenting to allow Dragon's Life Systems, Inc. to use and disclose the information in your testimonial and acknowledge that your testimonial may be distributed to the public.

**Right to Revoke:** You have the right to revoke this Release at any time by providing written notice of your revocation and submitting it to Dragon's Life Systems, Inc. Please understand that revocation of this Release will not affect any action Dragon's Life Systems, Inc. took in reliance on this Release before receiving your revocation.

## CONSENT TO RELEASE

I hereby authorize Dragon's Life Systems, Inc. to use my testimonial and any information contained herein in its public relations efforts. I understand and approve the disclosure of testimonial information to the media and other individuals and entities that may be involved in the public relations efforts of Dragon's Life Systems, Inc.

I understand that I am providing the testimonial information to Dragon's Life Systems, Inc. and that my treating healthcare provider will not be providing any protected information to the media or the public, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release Dragon's Life Systems, Inc. from any and all claims for damages of any kind based on the use of my testimonial or information in the testimonial. By signing below I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Consent to Release my Patient Testimonial.

\_\_\_\_\_  
Patient's Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature



# DRAGON'S LIFE SYSTEMS

ACUPUNCTURE | CHINESE MEDICINE | CHIROPRACTIC

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## PATIENT TESTIMONIAL FORM

Name/Initials/Pseudonym: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_  
Date: \_\_\_\_\_  
Condition Treated: \_\_\_\_\_

**Note:** If possible, please also kindly add your testimonial on Yelp.com at <http://www.yelp.com/biz/dragons-life-systems-chicago>.

Please check this box if you wish to have your testimonial added on Yelp.com by Dragon's Life Systems, Inc.

Please describe your experience with us (limit to 2 pages):



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Name/Initials/Pseudonym: \_\_\_\_\_

*Thank you for your testimonial.*