

AUTHORIZATION AND RELEASE INFORMATION

I understand my testimonial as outlined below ("Testimonial Statement") and made on behalf of Kellis Eye Center (hereinafter called "The Company") may be used in connection with publicizing and promoting The Company. I authorize The Company to use my <u>first</u> name, type of surgery performed, photographs, video and the Testimonial Statement as defined on this form.

I hereby irrevocably authorize the company to copy, exhibit, publish, or distribute the Testimonial Statement, photographs or video for purposes of publicizing The Company's programs or for any other lawful purpose. These statements/photographs/video may be used in printed publications, multi-media presentations, on websites or social media, or in any other distribution media. I agree that I will make no monetary or other claim against The Company for the use of the statements/photographs/video.

In addition, I waive the right to inspect or approve the finished product, including written copy, wherein my likeness or my testimonial statement/photograph/video appears.

I hereby hold harmless and release The Company from all claims, demands and causes of action which, I, my heirs, representatives, executors, administrators or any other person acting on my behalf, or on behalf of my estate have or may have by reason of this authorization.

I have read the AUTHORIZATION AND RELEASE INFORMATION and give my consent for the use as indicated above.

Printed Patient Name:							
Signature:		, al		TO THE STATE OF TH			
Telephone <u>and</u> Email:							
Date Signed		1 11		15 %	-3	- 17 - 18 - 18 - 18 - 18 - 18 - 18 - 18	
Surgeon and Procedure	8		, 1				, i'
Testimonial Statement: In problems you experience the benefits of ocular sur	d), and h	ow it has cha	anged. You	r feedback	will help fut	ure patient	surgery (i.e. ss understand

Need more space for your testimonial statement? Feel free to continue it on the back of this paper.