Novus
Neurology | Psychiatry | TMS

Patient Testimonial Release Form

Name: _____ Date:_____

Thank you for taking the time to share your experience with Novus Neurology/Psychiatry/TMS. We value and appreciate your expression. Your success story may serve as an inspiration and encouragement to others. Once complete, please give to staff member or email this form to info@novustms.com.

Your Story:

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Some questions to reflect on…

1. **How has your daily life improved?**
2. **Would you recommend Novus to a friend or relative?**
3. **What do you consider to be the most valuable aspect of your experience with us?**

Authorization and Release of Testimonial Information

I understand my testimonial as outlined above and made on behalf of Novus Neurology/Psychiatry/TMS may be used in connection with publicizing and promoting the practice. I authorize the practice to use my name, brief biographical information, and the testimonial as defined on this form.

I hereby irrevocably authorize the practice to copy, exhibit, publish, or distribute the testimonial for purposes of publicizing the practice's services or for any other lawful purpose. These statements may be used in printed publications, multimedia presentations, on websites, social media or in any other distribution media. I agree that I will make no monetary or other claim against the practice for the use of the statement. In addition, I waive any right to inspect or approve the finished product, including written copy, wherein my testimonial appears.

I have read the authorization and release information and give my consent for the use of my testimonial as indicated above.

Printed Name:_____

Signature:_____

Email and City/State:_____