Patient Testimonial Consent Form

Plastic Surgical Arts
4400 Lucile Drive, Ste 103
Lincoln, NE 68516
Todd Orchard, M.D., Mathieu Hinze, M.D., Angela Moran-Manzitto, PA-C

This is to certify that I have chosen to give my testimonial as a patient or client of Plastic Surgical Arts.
I understand that by submitting my testimonial it does not guarantee the use of my testimony. I understand that by submitting my testimonial I allow the use of my testimonial for reproduction in any medium including but not limited to; website, video, broadcast, print, and electronic means for purposes of advertising, trade, display, exhibition or editorial use. The undersigned releases Plastic Surgical Arts from all claims for libel, slander, invasion of privacy, infringement of copyright or right of publicity or any other claim.
Approved quotation: (please sign exactly how you would want this to appear on our website/ social media platforms - initials, first name, anonymous, or full name)

Desired Signature w/testimonial_____

The undersigned is an adult and fully authorized to sign this Consent and Release form.

_____
Signature

_____
Printed Name

_____/_____/_____
Date

Please submit this by fax to: (402) 483-2619
or submit via email to:
lincolnplastics@gmail.com
or mail to:
Plastic Surgical Arts
4400 Lucile Drive, Ste 103
Lincoln, NE 68516