Ilyas Munshi, M.D.
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Video Patient Testimonial Release Consent

Purpose of Consent: By signing this form, you are hereby consenting to allow ***ILYAS MUNSHI, M.D.*** to use and disclose the information you provided in your video patient 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 the contact person listed below. Please understand that revocation of this release will not affect any action **Ilyas Munshi, M.D.** took in reliance on this release before receiving your revocation.

CONSENT TO RELEASE

I hereby authorize **Ilyas Munshi, M.D.** and staff to use my video 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 **Ilyas Munshi, M.D..** I understand and acknowledge that the media may be interested in telling my story, and I am willing to cooperate and participate in media interviews should the need arise.

I understand that I am providing the video testimonial information to **Ilyas Munshi, M.D.** 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 **Ilyas Munshi, M.D.** from any and all claims for damages of any kind based on the use of my video testimonial or information provided within the video 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 video patient testimonial.

_____

Signature Date

_____

Print Name

Please provide your contact information:

_____

Address

_____

Phone Email