Ilyas Munshi, M.D.
Neurological Surgery – Board Certified
99 W. Martial Avenue
Lafayette, LA 70508
Phone: (337) 234-5344 Fax: (337) 234-5311

SHARE YOUR STORY!

You have been a patient of Dr. Munshi's and have seen first hand results! Help us share your story with the world! Has Dr. Munshi relieved your pain and given you back the ability to enjoy life? Has he helped you avoid surgery? Has his treatment changed your world and improved your life? Whatever your testimonial, don't keep it to yourself!

Fill out the short questionnaire below (feel free to use the back or a separate sheet of paper if you need more room). When you are finished, please read and sign the release on the next page to give us permission to use your testimonial. Then simply turn the testimonial in, or send it to us using the contact information above. We might just share your story with other patients, or even the media! We love to hear how we have helped improve the health, wellness and quality of life of our patients. Your testimonial could help improve the lives of others by showing how your life has been positively impacted.

1. Why did you seek care from Dr. Munshi? What type of problem were you experiencing/what was your diagnosis:

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2. How has the care you received from Dr. Munshi improved your life?:____

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3. What would you say to a friend or family member who was curious about care?:

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4. What has pleased you most in your course of treatment at our practice?

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5. **Additional notes/comments:**

Please read and sign the **Patient Testimonial Release Consent** form on the following page.

Thank you!

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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 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 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 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 as they arise.

I understand that I am providing the 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 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.

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Signature   Date

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Print Name

Please provide your contact information:

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Address

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Email   Phone