Patient Testimonial Consent Form

Please fill out the form below if you are interested in submitting a patient testimonial for Maryland Eye Associates.

Name: _____ Patient Name: _____
(Your first and last name) (Enter name of Patient)

Email: _____ Phone Number: _____

Testimonial:
Please share your experience to help us serve you better. Let us know how you feel about our doctors and staff, your overall surgery experience, improvements in your vision and more…
(Write your testimony here.)

Consent:
☐ **I Agree** (please ✓ in the box if you agree)

This is to certify that I chose to give my testimonial as an eye patient being treated by Maryland Eye Associates. I understand by submitting my testimonial it does not guarantee the use of my testimony. I understand by submitting my testimony, I give Maryland Eye Associates the right to use 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 Maryland Eye Associates from all claims libel, slander, invasion of privacy, infringement of copyright or right of publicity or any other claim. I hereby agree to have my name appear as in any posting or publication. The undersigned is an adult and fully authorized to sign this Consent and Release Form.

Patient Name: _____ Patient Signature: _____
Date: _____