HILO NATURAL HEALTH CLINIC

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www.HiloNaturalHealth.com ● *"Strong Medicine, Gentle Healing"*

TESTIMONIAL USE FORM

This is to certify that I, _____, give permission for Dr Sarah Strong, ND to use the following written or attached testimonial (signed and dated if attached) for advertising purposes. I understand that this testimonial may be used in part or in full and minor changes may be made only to ensure grammatical accuracy. I understand that any changes to the content will not alter the meaning in any way and that the use of this testimonial will not expire. I understand that any additional testimonial information that I may provide (photos, videos, online postings, etc) may also be used for advertising purposes by Dr Strong. I understand that only the name (or initials) listed below may be used for marketing purposes. I also understand that no additional information will be disclosed regarding treatments outside of the testimonial given. All other HIPPA compliance will remain in effect. Full disclosure of identity will not be used unless indicated on the testimonial itself.

_____ _____
Name to be used on testimonial City

_____ _____
Signature Date

Testimonial: