



315 S CHURCH ST SUITE C  
HENDERSONVILLE, NC 28792  
PHONE (828) 435-2377  
FAX (828) 412-4382

EMAIL DRANDREA@GRACECHIROPRACTIC.COM

**SHARE YOUR CHIROPRACTIC STORY!**

You've been a Chiropractic patient and you've seen firsthand how effective it can be! Help us share your story with the world. Has Chiropractic relieved your pain and given you back the ability to enjoy life? Has it helped you avoid surgery? Has Chiropractic improved your overall health? Whatever your testimonial, don't keep it to yourself!

Help us share the healing power of chiropractic by filling out this short questionnaire below. When you are finished, please read and sign the release on the next page to give us permission to use your testimonial. We would love to hear how we have helped improve the health, wellness and quality of life of our patients with Chiropractic care. Your testimonial could help improve the lives of others by showing how Chiropractic has positively impacted your life.

**1. How has Chiropractic care improved your life?:**

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

**2. What would you say to a friend or family member who was curious about Chiropractic Care?:**

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---



315 S CHURCH ST SUITE C  
HENDERSONVILLE, NC 28792  
PHONE (828) 435-2377  
FAX (828) 412-4382

EMAIL DRANDREA@GRACECHIROPRACTIC.COM

---

---

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

---

---

---

---

---

---

---

---

---

---

**4. Additional notes/comments:**

---

---

---

---

---

---

---

---

---

---

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

**Patient Testimonial Release Consent**

Purpose of Consent: By signing this form, you are hereby consenting to allow Grace Chiropractic to use and disclose the information in your testimonial and acknowledge that your testimonial may be distributed to the public.



315 S CHURCH ST SUITE C  
HENDERSONVILLE, NC 28792  
PHONE (828) 435-2377  
FAX (828) 412-4382

EMAIL DRANDREA@GRACECHIROPRACTIC.COM

**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 Grace Chiropractic. Please understand that revocation of this Release will not affect any action Grace Chiropractic took in reliance on this Release before receiving your revocation.

**CONSENT TO RELEASE**

I hereby authorize Grace Chiropractic 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 Grace Chiropractic 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 Grace Chiropractic 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 Grace Chiropractic 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.

---

Signature

Date

---

Print Name

**Please provide your contact information:**

---

Address

---

Phone

Email