# Patient Testimonial Consent Form

Plastic Surgical Arts
4400 Lucile Dr, #103
Lincoln, NE 68516
Todd Orchard, M.D., Mathieu Hinze, M.D.

This is to certify that I have chosen to give my testimonial as a patient or client of Plastic Surgical Arts.

I understand that by submitting my testimonial it does not guarantee the use of my testimony. I understand that by submitting my testimonial I allow the use of 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 Plastic Surgical Arts from all claims for 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 is in any posting or publication.

Please write/type your testimonial and specify how you wish to be identified (full name, first name, intitals, anonymous, etc) as this will appear on the website. thank you.

The undersigned is an adult and fully authorized to sign this Consent and Release form.

_____
Signature

_____
Printed Name

_____/_____/_____
Date

Please submit this form by fax to: (402) 483-2619 or email to: lincolnplastics@gmail.com