



# SHOCKWAVE THERAPY

## Photographic, Written or Video Consent Release Form

I, \_\_\_\_\_ do hereby release to Lemont Active Chiro, its agents and employees, all rights to exhibit my testimonial in print and electronic form publicly. I waive any rights, claims or interests to the use of my identity or likeness in the photographs or video and agree that any uses described herein may be made without compensation or additional consideration of me.

I am only waiving my privacy rights under HIPAA, insofar as the picture or accompanying endorsement imply or reveal that I am a patient or former patient of Dr. Timothy F. Filippini, D.C./AMT Healthcare/ Lemont Active Chiro. All other privacy rights under HIPAA are reserved, unless specifically released by me.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Guardian Name (required for minors): \_\_\_\_\_

Guardian Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_



