Patient Testimonial Consent Form

Ridha Arem, M.D., FACP, FACE

This is to certify that I have chosen to give my testimonial as a thyroid patient being treated by Dr. Ridha Arem, M.D.

I understand that by submitting my testimonial it does not guarantee the use of my testimony. I understand that by submitting my testimonial I give Dr. Arem 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 Dr. Arem 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.

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

____
Signature

____
Printed Name

______/______/_______
Date

Please submit this for by fax to: (713) 790-0007 or mail to:
Texas Thyroid Institute
Attention: Patient Testimonial
7501 Fannin Street, Suite 730
Houston, TX 77054