

# Patient Testimonial Consent Form

*Ridha Arem MD*

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

I understand that a submission on my part does not guarantee use of my testimony. Furthermore, I acknowledge that any information that I provide may be used at any time for patient testimonials, or patient stories that may appear online or in future publications.

I also understand that I may submit my testimonial with the option to remain anonymous. If I am choosing this option, I have indicated that I wish to do so in the appropriate space designated below on this page. If I do not select the box below, I agree to have my name appear as is, in any posting or publication.

---

Patient Name (please print)

---

Patient Signature

---

Date:

---

I am electing to submit my testimony to be used anonymously.  
**\* PLEASE NOTE:** If you are selecting this option, you will still need to submit this form *COMPLETED* with your name and signature as your acknowledgement and confirmation of your testimony being submitted for use, however your name will be withheld from any posting or publication.

Return your form to Kimberly, by: Fax: (713) 979-0369  
Mail: Texas Thyroid Institute, 7501 Fannin St., Suite 730, Houston TX  
77054.