Salem Orthopaedic Surgery

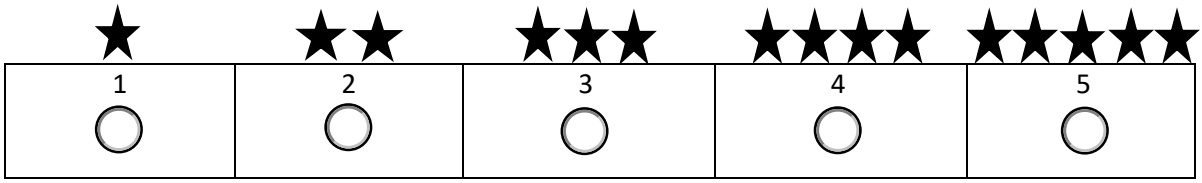
A Service of SALEM REGIONAL MEDICAL CENTER

Salem Orthopaedic Surgery invites you to share your experience to help other patients understand what to expect when having a procedure or surgery performed by one of our providers.

To Share Your Story: Please fill out the form below about your patient care experience and then complete the attached *Authorization and Release of Patient Testimonial* form below. When you are done, please email your patient story (photo optional) and the authorization form to: shareyourstory@salemregional.com.

We Value Your Feedback

Please check the box below that best describes your patient experience.



Please share “Your Story”

Authorization and Release of Testimonial Information

By signing this authorization and release, I authorize Salem Regional Medical Center (SRMC) and its affiliate offices ("Hospital") and its staff to use photographs, video images, voice, brief biographical information (limited to what I provide below), the attached written testimonial statement ("Testimonial") and other likenesses of myself, for advertising and marketing purposes including electronic media, television, print media, social media channels, and the SRMC website.

I acknowledge and understand that the Testimonial, photographs, video images, voice, brief biographical information provided below, and other likenesses of myself may be included in, copied, circulated, and distributed by means of various print ad and electronic media, such as print, television, social media, email, and website; and I agree that I will make no monetary or other claim against the Hospital for their use. I waive any right to inspect or approve the finished product where my Testimonial appears. I hereby hold harmless and release the Hospital from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf have or may have by reason of this authorization.

By signing this authorization and release, I acknowledge that I understand that authorizing the disclosure of my health information is voluntary and understand that I may refuse to sign this authorization.

I acknowledge that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to the Salem Regional Medical Center Public Relations and Marketing Department, 1995 East State Street Salem, Ohio 44460. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, I understand that this authorization will expire in two (2) years from the date of signature.

I acknowledge that I have read and agree to the authorization and release terms outlined above; and have been provided with Salem Orthopaedic Surgery's Notice of Privacy Practices: Click Here.

Printed Full Name: _____

Signature: _____

Date: _____

Email: _____

Phone: _____

Address: _____

Date of Birth: _____

The parties agree that this agreement may be electronically signed and that the electronic signature appearing on this agreement is the same as a handwritten signature for the purpose of validity, enforceability and admissibility.

Please email your completed testimonial (photo optional) and authorization form to: shareyourstory@salemregional.com