Patient Testimonial & Publication Authorization

Optional. Declining will not affect care. Complete only after the patient has reviewed the exact statement and intended use.

TESTIMONIAL

Exact testimonial text authorized for publication

ATTRIBUTION - SELECT ONE

- [ ] Anonymous patient
- [ ] Initials only
- [ ] First name only
- [ ] Review-platform username
- [ ] Full name - separately confirmed

Authorized attribution

INFORMATION THAT MAY BE DISCLOSED

- [ ] General patient experience only
- [ ] Procedure name
- [ ] Approximate age range
- [ ] City/state
- [ ] Photographs under a separate signed photo authorization
- [ ] No medical or procedure details

AUTHORIZED USES

- [ ] Labia Cosmetica website
- [ ] Practice-controlled social media
- [ ] Print materials
- [ ] Digital advertising
- [ ] Third-party review platform named below

Authorized platforms and limitations

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I understand that the testimonial reflects my individual experience and does not guarantee another patient's result. I authorize only the exact text, attribution, disclosures, and uses selected above. I may revoke future use in writing, but revocation will not affect prior lawful publication or third-party copies beyond the practice's control.

SIGNATURE

Printed name

Date

Signature (sign after printing or use an approved e-signature workflow)

By signing, I confirm that I reviewed this form and that the information I provided is accurate to the best of my knowledge.