Stargate Clinic
2824 Merchant Drive • Knoxville, TN 37912
www.stargateclinic.com

Stargate Clinic – Client Video Consent & Testimonial Release Form

Patient Consent for Video Recording, Testimonial Use, and Online Publication

I, the undersigned, hereby give permission to Stargate Clinic and Dr. David Velarde to record my image, voice, and statements in a video format for the purpose of sharing my testimonial regarding the services I received.

Purpose

The video testimonial may be used for educational, informational, or promotional purposes, including but not limited to posting on the clinic's website, social media platforms, and other online or offline media.

Medical Content Disclosure

I acknowledge that I may discuss aspects of my medical condition or treatment during the video testimonial. I consent to the inclusion of such information for the purposes described above, and I understand that this information may be accessible to the public once published.

Voluntary Participation

My participation is entirely voluntary. I understand that I will not receive financial compensation for the use of my video testimonial.

Confidentiality

I understand that once the video is published, it may be viewed by the public. I consent to the use of my name, likeness, voice, and any statements I make in the recording.

Right to Revoke

I understand that I may revoke this consent at any time before the video is posted online by submitting a written request. However, once published, removal may not be guaranteed.

Release of Liability

I release Stargate Clinic, Dr. David Velarde, and their representatives from any and all claims, liabilities, or damages that may arise from the use of the video as described above.

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HIPAA & Health Privacy Waiver

I understand that if I voluntarily disclose aspects of my medical treatment or condition in this testimonial, that information is no longer protected under HIPAA once made public. I release Stargate Clinic and Dr. David Velarde from any HIPAA-related liability associated with this disclosure.

Tennessee Right of Publicity Acknowledgment

I acknowledge and agree that the use of my name, image, or likeness in this testimonial is authorized and does not violate my right of publicity under Tennessee Code Annotated § 47-25-1101.

Consent for Recording on Medical Premises

If this recording takes place inside a licensed healthcare facility, I consent to be recorded for testimonial and marketing purposes. No protected patient health records are being accessed or disclosed during this process.

Consent Confirmation

By signing below, I confirm that I understand and agree to the terms stated above.

Patient Name (Printed): _____
Signature: _____
Date: _____

Witness Name (Optional): _____
Witness Signature: _____
Date: _____