THE HAND & WRIST CENTER
Specialists in diagnoses, rehabilitation and surgery

NEEDLE APONEUROTOMY – TESTIMONIAL CONSENT

I have been informed by ***The Hand & Wrist Center***, of their interest in "sharing" limited information regarding my ***Needle Aponeurotomy*** procedure experience. I understand that the intent to share information, in relation to my procedure, is to raise awareness and help educate other patients about ***Needle Aponeurotomy*** services available at ***The Hand & Wrist Center***.

With my Testimony and signature below, I give permission to the ***The Hand & Wrist Center*** to share my information, which may or may not include "Before and After" pictures, with other patients and inquiring parties. I further understand, that the information contained below will be the extent of Testimonial Consent, and at NO time, will any other medical chart information be shared without further consent.

Lastly, I understand that my information may be shared in printed media or web media formats at the discretion of ***The Hand & Wrist Center***.

PATIENT NAME (PRINTED): _____

TESTIMONIAL:
(In 75 words or less, please provide us with a summary of your expereince having undergone your Needle Aponeurotomy procedure in our Office)

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Patient Name (printed): _____

Patient Signature: _____

Date: _____

04/2009 HWC