CHAO VISION INSTITUTE
Commitment | Expertise | Integrity

TESTIMONIAL CONSENT

Name (Last, First):

May we use a photo/ video clip of you?

Occupation/ Title:

City, State:

Vision Care/ Procedure Received:

1. How did you hear about Dr. Chao and/or Chao Vision Institute?

2. What motivated you to consider vision correction?

3. Please describe your overall CVI experience with Dr. Chao and/or Chao Vision Institute.

4. Based on your experience, please give the reason(s) you would recommend the vision care/ procedure and Dr. Chao to your family and friends.

5. How have you been enjoying the way you see the world? Please share with us your perspective of what life has looked like after refractive surgery.

I give my full and complete permission, without compensation or limitation to Chao Vision Institute, Inc. to take, record, publish, display or obtain testimonials or other statements from me in any media, by any means, methods including, but not limited to, educational, advertising, marketing and promotional materials. This consent is granted for an undefined period. I agree that the foregoing testimonials represents a "Statement or Testimonial" by me. I understand and agree that the Statements may be used with or without identifying me and my affiliation. I represent and warrant that I am over the age of eighteen (18) years; have read and understand the contents of this Release.

Signature of Patient/ Representative	Date