



Patient Testimonial Release Form

Authorization and Release of Testimonial Information

I understand my testimonial as outlined below (the "Testimonial") and made on behalf of [Florida Joint & Spine Institute, P.A.] (Hereinafter called "The Practice") may be used in connection with publicizing and promoting The Practice. I authorize The Practice to use my name, brief biographical information, and the Testimonial as defined on this form.

I hereby irrevocably authorize The Practice to copy, exhibit, publish or distribute the Testimonial for purposes of publicizing The Practice's services or for any other lawful purpose. These statements may be used in printed publications, multimedia presentations, on websites or in any other distribution media. I agree that I will make no monetary or other claim against The Practice for the use of the statement. In addition, I waive any right to inspect or approve the finished product, including written copy, wherein my testimonial appears.

I hereby hold harmless and release The Practice from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

Signature: Roy Middleton

I have read the authorization and release information and give my consent for the use of my testimonial as indicated above.

Print Name: Roy Middleton

Email: DITCHERD101@gmail.com

Address: 4105 U.S. Hwy 27 S. Cot 90

City, State, Zip: SEBRING, FL 33870

Procedure Performed: KYPHOPLASTY

Physician Name: DR. THAKUR

Testimonial Statement:

I would highly recommend having spine & joint treatment procedures to make a body whole again. This place helped me being whole as I walked in here bent over and walked out ~~straight~~ up. ^{STRAIGHT} worth the visit

AAA



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Signature: Patricia Laposa

I have read the authorization and release information and give my consent for the use of my testimonial as indicated above.

Print Name: Patricia Laposa

Email: matalosa2@live.com

Address: 1932 Sunflower Circle

City, State, Zip: Sebring, FL 33872

Procedure Performed: MILD procedure (Minimally Invasive Lumbar Decompression)

Physician Name: Dr. Anand Thakur

Testimonial Statement:

I can only attest that I was in pain for many years, coming to Dr Thakur was the most informed person I have ever met. His information regarding the Mild Procedure, was something that at first



gave me pause to think about, but as I did, I made up my mind very quickly that this was the way to go, and Dr Thakur is definitely the person who is very well versed in this procedure.

I can definitely say I love his demeanor, and the care he gives his patients.

Name: Patricia Laposo Date: 4/1/24



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Signature: Frederick G. Khouri, Jr. _____

I have read the authorization and release information and give my consent for the use of my testimonial as indicated above.

Print Name: _Frederick G. Khouri, Jr. _____

Email: _____

Address: _____

City, State, Zip: _____ Sebring, FL 33872 _____

Procedure Performed: _____ March 2024 _____

Physician Name: _____ Dr. Thakur _____

Testimonial Statement: Could not be happier. Treated me extremely well, explained the procedure. Took some time to "Kick IN" but I'm getting better every day. Hat's of to Tiffeney and she walked through the entire authorization as professionally as anyone could be.