axiscommunityhealth

PATIENT FEEDBACK FORM

Today's Date: _____

All information may be submitted anonymously. Identifying information is not required.

Name: _____

If you are submitting feedback someone's behalf, provide the name and date of birth of the person on whose behalf you are filing:

Name: _____ Date of Birth: _____

Please leave feedback you have below with details like the date of your visit or the name(s) of any Axis Staff Members.

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PATIENT TESTIMONY RELEASE

My signature indicates that I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

- I understand my testimony, may be used in connection with publicizing and promoting Axis Community Health.
- I authorize Axis Community Health to use my name and testimonial.
- I grant Axis Community Health and its representatives and employees the right to use my name, testimonial in various marketing initiatives.
- I understand that this information may be used in various mediums for such purposes as publicity, illustration, advertising and Web content.
- I authorize Axis Community Health to copyright, use and publish these materials in both print and electronic formats for purposes of publicizing Axis Community Health
- I hereby hold harmless and release and forever discharge Axis Community Health and its officers, directors, board members, employees, volunteers, agents, independent contractors and vendors from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other person acting on my behalf of my estate have or may have by reason of this authorization.

Patient/Client or Legal Representative's Signature

Date

Relationship (if not patient or client)

Send to: Chief Operating Officer
5925, W. Last Positas Blvd., Suite 100
Pleasanton, CA 94588
Fax: (925) 417-1503

For Internal Use Only

HIPAA Related? **NO YES (Route to Compliance Officer)** MRN: _____

Action Taken:

Resolution Date:_____

Resolution Reached? **NO YES (Attach copy of written response if appropriate)**

Print Name: _____ Signature: _____

This document is for quality assurance purposes and will not be disclosed without approval. REV 07/2022