Testimonial Release Form
for Avenues to Medicine, Ltd. Co.

Please print all information clearly

Questions? Call 877-788-5644

Name: _____ Phone: _____

Address: _____

Please identify who you are:
_____ Individual receiving medications directly _____ Healthcare provider ____ Caregiver

Testimonial statement: Please describe how Avenues to Medicine has made a difference in your ability to receive medications. If you are a client, how much money are you saving each month? If you are a caregiver, how do our services help your patients?

Would you like your photograph to be listed next to your testimonial on our website? Yes / No
If so, please send a clear photo of yourself along with this testimonial to:

Avenues to Medicine, P.O. Box 151, Seymour, CT 06483

Through my signature below, I hereby authorize Avenues to Medicine, Ltd. Co. to print my testimonial, in full or in part, and to use my photograph in any marketing materials and on their website. **Note: Only First Name, First Initial of Last Name, City and State will be printed**.

The information stated above is accurate and true to the best of my knowledge.

_____ _____
Signed Date