



Tell us how we made a difference in your life!

Encourage others to use our services by sharing your success story!
Please fill out, download and email this PDF to firstsuneap@firstsuneap.com

I prefer to be identified in the following way for my testimonial:

My first name and last initial only (Maria S.) First Name Last Initial

My first and last initial only (M.S.) First Initial Last Initial

Please leave my identity anonymous.

I am ... An employee A family member
(Please select one.) A member of management I prefer to remain anonymous.
A human resources professional

Please share your experience:

**This is a voluntary program and is not a condition of employment.
(If you choose to submit, please see details on the last page of this form.)

Large text area with horizontal lines for sharing experience.

Client Testimonial Release Authorization Form

Purpose of Authorization: By signing this authorization form, I am providing First Sun EAP to distribute and share my client testimonial that I provided. Sharing my client testimonial may include posting the information on the company website, posting the testimonial information on First Sun EAP's social media pages, and including my testimonial on printed advertisements and promotions. I agree that I am voluntarily sharing my testimonial about services from First Sun EAP, and I am receiving no financial remuneration from First Sun EAP for providing my testimonial and allowing them to use my protected health information for marketing purposes.

Right to Revoke: I understand that I have the right to revoke this authorization at any time by providing a written request to the Privacy Officer at First Sun EAP. I understand that if I choose to revoke this authorization, it will become effective on the day of the revocation of the authorization. Any prior uses and disclosures of my testimonial with my protected health information will not be subject to the revocation of the authorization. I understand that First Sun EAP will make it best effort to remove my testimonial and protected health information from First Sun EAP's website and other social media pages.

Components of My Testimonial: I understand that the client testimonial for First Sun EAP will only include my name, photograph, and information provided to the organization in my testimonial. I understand that all other protected health information that First Sun EAP creates and maintains for purposes of my care will not be used in my testimonial or for marketing purposes without prior authorization per privacy regulations of the state and Health Insurance Portability and Accountability Act (HIPAA).

By signing below, I agree and acknowledge that I have read and understood all of the elements of this authorization for use of my client testimonial. This authorization will expire 12 months after the date of the signature. After the expiration, I understand that First Sun EAP will not be allowed to use my testimonial for any future marketing purposes. It does not require First Sun eAP to remove my testimonial from the website or other social media pages unless I specifically request a revocation of this authorization.

Signature: _____ Date: _____

If not client, relationship to client: _____

Name (Printed): _____

Would you like a First Sun EAP professional to follow up with you?
(If you have an issue that needs attention, we will be happy to give you a call.)

First & Last Name: _____

Phone Number: _____ Email: _____

I am at least 18 years of age.

Please use submit button or download this PDF and email to firstsuneap@firstsuneap.com

If you wish to mail or fax your testimonial, please download the form, completely fill out all pages and send to:

First Sun EAP

2700 Middleburg Drive, Suite 208

Columbia, SC 29204

Or FAX to: 803-799-3772



800-968-8143 • www.firstsuneap.com