OSTEODOX
PATIENT CONSENT FORM

We understand that at times patients may not return phone calls or respond to letters regarding their account/file and they may need to have someone call on their behalf. Due to HIPPA (Health Insurance Portability and Accountability Act), we may not discuss any information regarding a patient without their signed consent.

By signing this form, I _____ , give Osteopathic Medical Associates of Nevada the authorization to release and discuss any information about myself to the following people:

NAME	NAME

I understand that it is my responsibility to notify the office of any changes.

PATIENT NAME	
PATIENT SIGNATURE	DATE

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