CONSENT TO DISCUSS PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Nevada state laws prevent this office form discussing patient information without the express written consent from the patient. If you would like this office to be able to discuss your medical care with someone other than yourself, please list the name of the individuals below. Any person on this list must be able to verify your date of birth as an added security measure. This may include tests and/or billing information.

Name of Patient	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature: _____ Date: _____

Patient Name: _____

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