



SHARE YOUR DO STORY!

DO and Osteopathic Medicine Patient Testimonial

How did your DO help you?

When it comes to the medical care your DO provided, what stands out (i.e. amount of time spent with you, quality of care, osteopathic manipulative treatments, etc.)?

What would you say to a friend, who was looking for a doctor, about your DO?

Who is your DO? Please provide us with the DO's contact information (name, address, phone number).

Patient Testimonial Release Consent

Purpose of Consent: By signing this form, you are consenting to the New Jersey Association of Osteopathic Physicians and Surgeons' (NJAOPS) use and disclosure of the information in your testimonial and acknowledgement that the testimonial may be distributed to the public.

Right to Revoke: You have the right to revoke this Release at any time by giving us written notice of your revocation and submitting it to the Contact Person listed below. Please understand that revocation of this Release will not affect any action the NJAOPS took in reliance on this Release before receiving your revocation.

CONSENT TO RELEASE

I hereby authorize NJAOPS to use my testimonial and any information in the testimonial in its public relations efforts. I understand and approve the disclosure by NJAOPS of testimonial information to the media and other individuals and entities that may be involved in NJAOPS' public relations efforts. I acknowledge that the media may be interested in my story, and I am willing to participate in media interviews as they arise.

I understand that I am providing the testimonial information to NJAOPS and that my treating physician will not be providing any information to NJAOPS, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including, Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release NJAOPS from all claims for damages of any kind based on the use of my testimonial or information in the testimonial.

I am of legal age and freely sign this release, which I have read and understood.

Signature

Print Name

Date

Please provide your contact information.

Name

Address

City, State, and ZIP code

Phone

E-mail

Please mail the completed form to:

New Jersey Association of Osteopathic Physicians and Surgeons
Communications Department
One Distribution Way, Suite 201
Monmouth Junction, NJ 08852

The form can also be sent via fax to **732-940-8899** or by e-mail to **bsmolen@njosteo.com**. If you have questions, please contact Communications Director Bonnie Smolen at **732-940-9000, ext. 304**.