SUMMIT ENT ASSOCIATES

5653 FRIST BLVD., STE 231 * HERMITAGE, TN 37076 * PHONE: 615.872.0922 * FAX: 615.885.8059

KENT R. MURPHY, M.D.

Release of Information Consent Form & Acknowledgement of Receipt, (if requested) of *Notice of Privacy Practices*

Date: _____

Patient Full Name: _____

Date of Birth: _____

As with all situations, these policies may differ for individual cases; however, we have attempted to make you aware of our policies. Please review the list below and mark the appropriate response. This page will be filed in your chart and will become part of your permanent medical record. If requested, we will be happy to provide you a copy of our **Notice of Privacy Practices** for your records. If you later decide that you would like to amend your answers, you will be required to complete a new form.

If the patient is a minor, please provide the information below for the parent or guardian.

May we contact you by phone at home? _____ NO _____ YES # _____
May we leave a message at home? _____ NO _____ YES # _____

May we contact you by phone at work? _____ NO _____ YES # _____
May we leave a message at work? _____ NO _____ YES # _____

May we send you a postcard reminding you of your appointment? _____ NO _____ YES

May we mail test results to your home? _____ NO _____ YES

May we fax test results to your home? _____ NO _____ YES # _____
May we fax test results to your work? _____ NO _____ YES# _____

I have read (or had read to me), and understand the policies outlined by Summit ENT Associates, Dr. Kent R. Murphy, regarding the release of information. I agree to these policies unless otherwise stated above.

If requested, I have received a copy of the Notice of Privacy Practices for Dr. Kent R. Murphy.

SIGNATURE OF PATIENT (Must be over 18 years of age) **DATE**

SIGNATURE OF PATIENT REPRESENTATIVE **DATE**
(Required if patient is a minor or unable to sign this form)

RELATIONSHIP TO PATIENT