Randall J. Falconer, MD
Accents
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1728 North Eastman Road, Kingsport TN 37664

Acknowledgement of Receipt of Privacy Practices
Authorization for Release of Information

I, _____ have received a copy of the Notice of Privacy Practices from the office of Randall J. Falconer, M.D., P.C.

I, _____ give my consent, do not give my consent (please circle one) to have my medical care including labs, test results, medications, diagnosis and treatment discussed with the following person(s):

Name_____Relationship_____Telephone: _____

Name_____Relationship_____Telephone: _____

Name_____Relationship_____Telephone: _____

May we contact you at work? Yes_____ No_____ Telephone:_____

May we leave messages on your machine? Yes _____ No_____

May we identify the name of the practice and person calling when we leave a message at your home or work number? Yes_____ No_____

I here release Randall J. Falconer, M.D., P.C. from all liability that may arise from the release of information requested or obtained.

_____ _____

Date Signature of Patient or Responsible Party

Witnessed By: _____ Date _____