MRN #___________

HIPAA RELEASE FORM

<u>*MUST COMPLETE ENTIRE FORM***</u>**

PATIENT NAME: ___________________________________ DATE OF BIRTH _____/_____/_____

___________________________________	_______________________	________________________
Your Name (guardian if under 18yrs of age)	**Best Contact Phone #**	**Alternate phone #**

****CHOOSE ONE****

☐ **<u>I give permission</u> to the physicians and their staff at Summit Medical Group to leave messages at the contact phone number(s) listed above any information regarding results, diagnoses, and appointment information, if I am unavailable.**

☐ **<u>I DO NOT</u> wish for messages to be left on my phone, MAY ONLY SPEAK TO ME**

Privacy regulations require us to have a release signed by our patients, so we may speak with family members, friends and other relations regarding your health information. Each person you wish to be considered a contact must be listed individually by name (including both parents, Spouse or Significant Other).

ALTERNATE CONTACTS:

________________________________	______________	_______________________
Name	Relation	Phone # best reached
________________________________	______________	_______________________
Name	Relation	Phone # best reached
________________________________	______________	_______________________
Name	Relation	Phone # best reached

SIGNATURES

X____ _____/______/_____

Patient Signature (Guardian Signature if patient under 18yrs of age) *Date*

____ _____/______/_____

Employee/Witness Signature *Date*