

DONALD D. DAVENPORT JR, D.O.
CONSENT TO DISCLOSE INFORMATION

I, _____ acting on behalf of _____
give permission to Donald Davenport, D.O. to give out information as
indicated below.

PLEASE INITIAL ONE BLANK ONLY

_____ 1. I **give** permission for the staff to tell anyone inquiring of me
being in the office for an appointment, date of next appointment
status as a patient, diagnostic test results, billing and insurance,
etc.

_____ 2. I **give** permission for the staff to release information regarding
me being in the office and for an appointment, date of next
appointment, status as a patient, diagnostic test results, billing
and insurance, etc., to the following person(s) only:

_____ 3. I **DO NOT** give permission to release information regarding
me being in the office for an appointment, date of next
appointment, status as a patient, diagnostic test results, billing
and insurance, etc. (This does not apply to other physicians involved
in patient care or insurance co. inquires in attempt to pay patient bill.)

Circle YES or NO For Each Number

I give permission for Dr. Davenport and or the doctor's representative to
contact me on my:

HOME PHONE	YES	NO	OTHER	YES	NO
WORK PHONE	YES	NO	LEAVE MESSAGE ON ANSWERING		
MOBILE PHONE	YES	NO	MACHINE OR VOICE MAIL	YES	NO

X _____
(SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE) (DATE)

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will
be used and disclosed. I understand that I am entitled to receive a copy of this document.

X _____
(SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE) (DATE)