TENPENNY
INTEGRATIVE MEDICAL CENTER

Tenpenny Integrative Medical Center
7380 Engle Road
Middleburg Heights, Ohio 44130

RELEASE FORM FROM PHONE CONSULTATIONS

I, _____, request a telephone consultation to discuss information regarding a question or laboratory result with a health professional at Tenpenny Integrative Medical Center (aka Tenpenny IMC.)

I agree to the following terms and conditions:

- I understand my consultation does not create a doctor-patient relationship, either before or after the consultation. I confirm the consultation is not personal medical or legal advice.
- My purpose in speaking with Dr. Tenpenny, or other health professionals at Tenpenny Integrative Medical Center, is to obtain information and an opinion, based on their research and experience. The consultation is for my general educational information only.
- I understand that the opinions and recommendations I am seeking are not necessarily inline with conventional medical recommendations regarding vaccinations and supplements and will make my own decisions accordingly.
- Information given to me is entirely at my own risk. The information is intended to supplement my personal understanding and research, and I am solely responsible for my decisions.
- I understand that the health professionals at Tenpenny Integrative Medical Center recommend that I make decisions about my health, and the health of my family, in partnership with a qualified healthcare professional in my local jurisdiction.
- My consultation may contain confidential and proprietary information and the information is intended for my use alone. Any information obtained during the consultation will not be shared with other parties, without the written consent of said healthcare practitioner.
- Tenpenny Integrative Medical Center will maintain as confidential any personal information shared during this consultation. However, as with all web-based and phone-based interactions, I understand that there are risks that unauthorized individuals my access this information and to that end, I assume responsibility for that risk and hold harmless Dr. Sherri Tenpenny, Tenpenny Integrative Medical Center, any agents, affiliates or professionals who are parties of this call.
- I agree that this consultation will **not** be recorded.

Name (print): _____
Signature: _____
Address:_____
Phone number: _____ Email address:_____ Date 02/26/2021
___ YES, please add me to your confidential email database.
___ NO, I do not what to be added to your email database.
___ I am already a member of your email database.

PLEASE FAX THIS FORM TO 440.239.3440 or email to INFO@TENPENNYIMC.COM
To maximize your consultation time, please also send a list of questions you wish to discuss.