Arizona Community Physicians, P.C.
Release of Information Form

Account #_____

Patient Name _____ DOB_____ Date_____

The confidentiality of our patients' medical information is very important to us. We understand there may be circumstances in which a family member or close friend needs access to your health information, or to the health information of someone under your care.

Please list the names and phone numbers of anyone who has your permission to have access to your medical records, or to your dependents medical records. This information is not limited to but includes appointments, billing information and test results.

Spouse's Name _____Contact Number_____

Child's Name_____ Contact Number_____

_____Contact Number_____

Parent's Name_____ Contact Number_____

_____Contact Number_____

Other's Name _____ Contact Number_____

DO NOT RELEASE Information to the following people: _____

Can we leave detailed lab results, radiological test results or any other imperative information on your mobile phone voice mail?_____ On your home voice mail?_____

Please check if applicable:

_____ I give permission for my child (of >15 years old) to be seen without the presence of an adult.

_____ I give permission for my child (of >15 years old) to have minor procedures or immunizations without the presence of an adult.

_____ I give permission for my child to be taken to medical appointments by:_____

_____

Patient/Parent/Guardian Contact Numbers: Home_____ Work_____ Other_____

Signature of the Patient or their Parent/Legal Guardian _____

I acknowledge that either I or the physician may, at any time, withdraw the option of releasing test information per the terms of this agreement, upon providing written notice. Any questions I had have been answered.

Form 116
01/20/2017