

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

Account # _____

Patient Name _____ DOB _____ Date _____

Guardian Name _____ Contact Number: _____

The confidentiality of our patient's medical information is very important to us. We understand there may be circumstances in which a family member or other adult needs access to your health information.

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

Name/relationship _____ Contact Number _____

Name/relationship _____ Contact Number _____

Name/relationship _____ Contact Number _____

By providing the below phone #(s) you are giving permission, to leave appointment information or detailed information regarding, lab results, radiological results or any other imperative information on the phone # indicated below

Cell/Mobile voice mail _____ (Phone #)

Home voice mail _____ (Phone #)

DO NOT RELEASE Information to the following people: _____

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.

Name Patient/Guardian: _____ Signature _____ Date _____

The information provided on this form will stay in effect until updated by the patient