

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

MRN # _____

Patient Name _____ DOB _____ Date _____

Patient/Parent/Guardian Phone Numbers: Home _____ Work _____ Cell _____

Is it okay to leave normal results on your answering machine or voicemail? **YES** or **NO**

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 dependent's 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 _____

_____ Contact Number _____

DO NOT RELEASE Information to the following people: _____

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 Signature or Parent/Legal Guardian _____