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

Account #_____

Patient Name _____ DOB_____ Date_____

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 child's health information.

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

Parent/Guardian name _____Contact Number_____

Parent/Guardian name _____ Contact Number_____

Other Adult _____Contact Number_____

Other Adult _____ Contact Number_____

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

Names _____

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?_____

DO NOT RELEASE Information to the following people: _____

Please check if your child is **16 years old or older** and you give permission for them to be seen without an adult:

_____ I give permission for my child to be seen without the presence of an adult.

_____ I give permission for my child to have minor procedures or immunizations without the presence of an adult.

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 Parent/Guardian: _____ Signature _____

Parent/Guardian Contact Numbers: Cell_____ Work_____ Other_____

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