



18555 N. 79th Ave, B-108
Glendale, AZ 85308

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
PATIENT RESPONSIBILITY FOR TEST RESULTS**

Patient _____

Birthdate _____

Phone: Home _____

Work _____

Cell _____

_____ I give permission for the office to call my workplace with test results

_____ I give permission to leave all test results on answering machine,
including NORMAL and ABNORMAL results.

_____ I give permission to share medical information with the following
individuals:

**Acknowledgment of Receipt of Privacy Practices and Patient Responsibility
for test results.**

I, _____ have received a copy of Arizona Family Care,PLCC's
Notice of Privacy Practices with an effective date of April 1, 2003 and I UNDERSTAND
THAT IF I HAVE NOT HEARD FROM THIS OFFICE WITHIN 2 WEEKS OF
THE TEST I SHOULD CALL THE OFFICE TO CHECK ON THE STATUS OF
THOSE RESULTS.

Signature of Patient _____

Date _____