



**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,
PLLC's notice of privacy practices with the 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: _____