Tucson Family Medicine MRN______________

Consent to *Release of Information* Form

Patient Name __________________________________ DOB________________ Date_______________

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 dependents 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/Parent/Guardian Contact #s: Home____________ Work_____________ Other_____________

Signature of the Patient or their Parent/Legal Guardian ____