Paseo Family Physicians
18275 North 59th Avenue
Building K, Suite 162
Glendale, AZ 85308
(602) 547-8184

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

Patient's Name: _____ Date of Birth: _____

I hereby Authorize Paseo Family Physicians (PFP) to release or disclose my medical record information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

How can we contact you: (PLEASE CHECK ANY OR ALL THAT APPLY.)
☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone** ☐ **Email**

Yes No I grant permission to leave test results or messages on my answering machine at home, at work, or any phone number provided by me. _____

Yes No I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

☐ Please check this box if you do not want your medical information discussed or disclosed with any family members

PATIENT CONTACT

We may disclose your medical information to a family member or friend who is involved in your medical care, or to someone who helps to pay for your care. (For example, we may leave messages with family regarding your treatment, appointment reminders and/or test results when you are not available.) If you do not want us to disclose your medical information to family members, check the box above restricting release to only you.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

Please be advised: Any health care record can contain personal and/or private information you may not want divulged such as STD results (sexually transmitted disease). HIV/AIDS testing, whether negative or positive, requires a separate form. This information may be directly generated by Paseo Family Physicians doctors as part of your care or it may be indirectly generated by requesting records from other treating doctors. All medical information contained in a patient's chart is necessary for complete and accurate treatment of your condition and will be released to the person(s) named above unless it is specifically stated only certain information may be released.

Patient Signature: _____ Date Signed: _____