Desert Pediatrics
5700 E Pima Ste G
Tucson, AZ 85712
520-721-5350

Release of Information

I, _____ hereby give my consent for my physician's office to provide lab, radiological testing or any other imperative information to:

☐ Myself by: _____ _____ _____ _____
Home Phone Answering Machine Work Other

☐ Spouse _____ Phone # _____

☐ Child _____ Phone # _____

☐ Parent _____ Phone # _____

☐ Other _____ Phone # _____

Please list any information that you would NOT like released and to whom:

_____

_____

_____

The following information will assist the office in contacting you with any diagnostic test or procedure result. We will maintain this form in your medical record. It will remain effective until you further notify us of any changes.

_____ _____
Patient Name Account #

_____ _____
Patient Signature Date