Arizona Community Physicians, P.C.
Minor Child Release Form

The confidentiality of our patients' medical information is very important to us. We understand there may be circumstances in which someone may need to care for your child. In order to provide the best medical care possible we would like you to provide us with the following information.

Please list the names of anyone who has your permission to be involved with your child's medical care. This permission will include appointments, medical decision making, authorizing treatment, authorization to release test results, etc.

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

☐ Spouse _____ Phone # _____

☐ Child _____ Phone # _____

☐ Parent _____ Phone # _____

☐ Other _____ Phone # _____

_____ Yes/No I give permission for my child to be seen without the presence of an adult. (Child is of age to drive themselves to their own appointment).

_____ Patients Name

_____ Account #

_____ Signature of Parent/Legal Guardian

_____ Date