

**Cactus Children's Clinic, P.C.**

5940 W. Union Hills Drive

Suite D100

Glendale, AZ 85308

(602) 978-2500

**AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**I hereby Authorize Cactus Children's Clinic (CCC) to release or disclose my medical record information to:**  
(please list parents/legal guardian)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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 medications, treatment, labs, or x-rays.

Yes    No    I authorize the release of any records regarding mental health.

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 person and/or private information you may not want divulged. 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.

\_\_\_\_\_  
Parent/Legal Guardian/Patient

\_\_\_\_\_  
Date Signed