The Wellness and Prevention Center, LLC
19841 N. 27th Ave Suite 204
Phoenix, Arizona 85027
623-387-3705

Consent for Release of Information and Test Results

Patient Name: _____

In order to ensure our ability to reach you promptly with the information required to service your health needs, we are asking you to complete the following consent.

I, _____ give my consent and authorization to the staff at The Wellness and Prevention Center, LLC to relay medical information and/or account information to the following persons. This information may include but is not limited to scheduled appointments, lab or radiological testing results, medication information or billing information.

PLEASE CHECK AND COMPLETE THE FOLLOWING:

Whom may we speak with; or who may we not give information to?

YES NO

[ ] [ ] Name: _____ Phone: ( )_____

[ ] [ ] Name: _____ Phone: ( )_____

[ ] [ ] Answering machine at home: ( )_____

[ ] [ ] Answering machine at work: ( )_____

[ ] [ ] Cell Phone: ( )_____

[ ] [ ] Other: _____ Phone: ( )_____

[ ] Contact and divulge information only to patient

_____ _____

Signature of Patient/Guardian Date

_____ _____

Relationship to Patient Staff Initials

Reviewed: 1/2/13, 1/1/14