ARIZONA INTERNISTS

Communication Consents

6565 E Greenway Pkwy Ste 102, Scottsdale, Arizona 85254 Phone (480) 900-7595 Fax (480) 739-0262
Michael Germain, M.D. & Danielle Wicklow, M.D.

PATIENT INFORMATION

Patient Name | Date of Birth (MM/DD/YYYY) | Phone Number

Address | City | State | ZIP Code

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION TO INDIVIDUALS

I authorize Arizona Internists to verbally discuss my medical care requested to the following individuals:

Name | Relationship | Phone

Name | Relationship | Phone

Name | Relationship | Phone

I understand the information to be released may include my past, present, or future health information including billing, treatment, records related to behavior and mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. I understand that I have the right to revoke my permission at any time except where Arizona Internists has already made disclosures in reliance upon this request. I understand this permission remains in effect until the time I revoke it in writing. If an updated PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION WITH FAMILY AND FRIENDS form is received and it has an identical family member/friend/other person listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file.

Signature of Patient/Authorized Representative | Date | Printed Name

Relationship to Patient or Description of Authority to Act for Patient (if applicable)

CONSENT TO LEAVE DETAILED VOICEMAIL MESSAGES

Arizona Internists may need to contact you about test results, appointments, referrals, or billing/insurance information. I give my permission for my provider(s) of care at Arizona Internists to leave detailed phone messages regarding my medical care/account information. I fully understand that this consent will remain valid until revoked in writing by me.

I give my permission to leave a detailed voice mail message at the number listed below.

Voicemail Phone Number

Signature of Patient/Authorized Representative | Date | Printed Name

Relationship to Patient or Description of Authority to Act for Patient (if applicable)