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Medical Information Release Form

I would like to participate in a Shared Electronic Medical Record (EMR) where Desert Life Primary Care, LLC may share information from my EMR with other facilities (ie: hospitals) and other healthcare providers and entities to improve the quality of my care (ie: procedures, treatments) and prevent potential delays in my care

I would like to opt out of a Shared Medical Record

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is NOT to be released to anyone

This release of information will remain in effect until terminated by me in writing

Messages

Please call my home my work my cell number my number on file

If unable to reach me:

You may leave a detailed message

Please leave a message asking me to return your call

Signature (Patient, Parent, Guardian, or Guarantor)