



ARIZONA DIGESTIVE HEALTH, P.C.

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VERBAL CONSENT FOR TEST RESULTS

Please list those with whom we may share your medical information/test results:

Name _____

Name _____

Relation _____

Relation _____

DOB _____

DOB _____

Phone _____

Phone _____

Name _____

Name _____

Relation _____

Relation _____

DOB _____

DOB _____

Phone _____

Phone _____

Please check the box if we may leave messages with your specific results on your voice mail.

Print Patient Name

Date

Signature

This includes verbal communication by phone or in person for copies of recent labs, x-rays, or procedure reports.