Physician Statement

Ability Dogs of Arizona
75 S. Montego Dr., Tucson AZ 85710
520-326-3412
contact@abilitydogsaz.org

I, _____, give my consent for the below named physician to release the information requested in this form.
(Patient's Name)

Signature: _____ Date:_____

If applicant is under age 18, Parent/Guardian must sign below:

Signature: _____ Date:_____

Print Name: _____

Dear Physician:

The patient listed above wants to train a dog in an Ability Dogs of Arizona Service Dog class. In order to verify that your patient has a qualifying medical condition, we would appreciate your answering the following questions.

Is the person listed above currently a patient of yours?_____ Date of last Tetanus shot:_____

What is the nature of the medical condition that this person would like to train the dog to assist with?

_____

_____

Is this patient taking medication related to this condition? ❑ Yes ❑ No

Is the person involved in therapy related to this condition? ❑ Yes ❑ No

Is there any additional information you would like to provide that would assist us to better meet the needs of this person?

_____

_____

Our classes are held at our indoor facility at 75 South Montego Drive, Tucson, AZ 85710. Feel free to visit or call us (520-326-3412). Thank you for your time.

Physician Signature_____

Physician Name _____**Date** _____

Address_____ **Phone** _____

Applicant information is privileged and confidential. This information is available to those involved in the applicant's consultation, training, recordkeeping, and billing. However, such information may only be accessed on a need-to-know basis. Need-to-know is defined as the minimum use, disclosure or access necessary for one to adequately perform one's specific responsibilities. All other access is prohibited unless authorization is obtained from the applicant or unless otherwise permitted by state or federal law.