



PROTECTED HEALTH INFORMATION (PHI)

Communication Consent Form

1. Patient Information

Patient Full Name: _____ DOB: _____

2. Disclosure

I authorize Northwest Colorado Health to discuss with the following individual(s) PHI regarding my current care and treatment:

Name _____ Name _____

Phone # _____ Phone # _____

Relationship to Patient _____ Relationship to Patient _____

3. Information to be Released/Accessed

The following information may be communicated verbally to the individual(s) named in Section 2

- checkboxes for Laboratory Results, Medical Instructions or Advice, Appointment Information, Prescription Drug Information, Billing, Insurance, and Payments, Adult Family Planning Treatment, Instructions, or Advice, Dental Treatment, Instructions, or Advice

4. Methods of Communication

I authorize Northwest Colorado Health to send messages regarding health information

- checkboxes for Home Phone, Cell Phone, Secure Messages via myClinicOnline, Text

5. I Understand That

- bullet points explaining the scope of the authorization, expiration, revocation, and disclosure rules

Patient Name

Patient Date of Birth

Patient Signature or Parent/Guardian

Relationship to Patient

Today's Date

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