NORTHWEST COLORADO HEALTH

PROTECTED HEALTH INFORMATION

CONSENT FORM

Help us communicate better with you.

1. I would like to get my communications (number in order of preference)

   ☐ In Person Only ☐Secure Messages via myClinicOnline

   ☐Phone: _____ ☐Text: _____

2. It is okay to leave a voicemail for all items selected below:

   ☐Medical ☐Behavioral Health ☐No Voicemails

3. I approve this agency to discuss my health with the below individuals:

   ☐No One - the agency is not allowed to discuss my health with anyone other than me

   _____/_____/_____
   Name Relationship Phone Number

   _____/_____/_____
   Name Relationship Phone Number

   _____/_____/_____
   Name Relationship Phone Number

4. It is okay to discuss all items selected, with the above contacts:

   ☐Laboratory Results
   ☐Medical Instructions or Advice
   ☐Appointment Information
   ☐Prescription Drug Information
   ☐Billing, Insurance, and Payments
   ☐Family Planning Treatment, Instructions, or Advice
   ☐Dental Treatment, Instructions, or Advice

_____ _____
Patient Name Patient Date of Birth

_____ _____
Patient Signature or Parent/Guardian Today's Date

This consent will remain in effect until revoked by the patient/parent/guardian, or in the case of a minor, on the date the minor becomes an adult under state law. Please advise us of any changes to your preferences.