



Help us communicate better with you.

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

☐ No Contact / 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

☐ Behavioral Health Treatment, Instructions, or Advice

☐ Medical Instructions or Advice

☐ Family Planning Treatment, Instructions, or Advice

☐ Appointment Information

☐ Dental Treatment, Instructions, or Advice

☐ Prescription Drug Information

☐ Billing, Insurance, and Payments

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.

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