PERMISSION TO DISCLOSE PERSONAL MEDICAL INFORMATION

Please provide us with the telephone number(s) you would like us to use when contacting you with medical information, such as results of tests, etc.

Home# _____

Work# _____

Cell# _____

We would also like you to provide names, if any, of those people with whom you feel comfortable with us relaying this information.

- o I prefer no information be released to anyone other than myself.
- o I give Boulder Women's Clinic permission to disclose health information to the following people.

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

MESSAGES

- o I prefer no messages are left on an answering machine or voicemail.
- o I give permission for Boulder Women's Clinic to leave messages with medical information or results on an answering machine or voice mail for the numbers listed above.

EMERGENCY CONTACT

Name: _____ Relationship _____

Phone# _____

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient of Legal Guardian Date