



Boulder Community Hospital

Boulder Community Hospital Physicians' Clinics

Beacon Clinic
Boulder Center for Sports Medicine
Buffalo Ridge Medical Associates
CMA - Lafayette

Family Medical Associates
Frontier Internal Medicine
Gunbarrel Medical Center
Holistic Family Practice
Internal Medicine Associates
– Balfour, Boulder, Foothills, Lafayette

Northwest Family Medicine
Pain Management
Spruce Street Internal Medicine
Table Mesa Family Medicine

Permission To Disclose Personal Medical Information

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

Patient Name: _____ **Date of Birth:** _____
(please print)

Primary Phone: _____ **Secondary #:** _____

Answering Machine Messages: (check one)

- ☐ I prefer only minimal notification be left on voice mail (who called, where they are calling from, and a number where they can be reached).
- ☐ I give permission to the clinic to leave messages, with discretion, of normal results on voice mail for the number(s) listed above.

Disclosure to Other Persons: (check one)

- ☐ I prefer no one be given information other than me.
- ☐ I give Boulder Community Hospital Physicians' Clinics permission to disclose health information to the following people:

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

Signature of Patient or Legal Guardian

Date: