Boulder Community Health
Ambulatory Services Department

***Clinic Name*:_____*Provider*:_____**

Communication of 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 #: _____

Voice Mail: (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 non-critical results and general medical information on voice mail for the number(s) listed above.
- ❒ I do not wish to have messages left on voicemail.

Disclosure to Other Persons: Please complete the BCH HIPAA Release of Information form if you would like any of your health information to be disclosed to an individual other than yourself.

- ❒ I do not authorize the release of information to any other individuals.
- ❒ I have completed the BCH HIPAA Release of Information.

_____ _____
Signature of Patient or Legal Guardian **Date:**