Consent to Disclose Personal Health Information

I hereby acknowledge that I may request and/or obtain the Notice of Health Information Privacy Practices from the AspenFamilyCare.com website.

____ ___________________________

Patient Name (Please Print) Date of Birth

____ ___________________________

Signature of Patient (or legal guardian if under 18 yo) Today's Date

Contact information for the patient:

Primary#: ______________________________

☐ Leave voicemail with detailed message

☐ Leave voicemail with call back number only

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If under 18 yo print name of parent/guardian

Alternate#: ______________________________

☐ Leave voicemail with detailed message

☐ Leave voicemail with call back number only

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If under 18 yo print name of parent/guardian

Please indicate who we can speak to regarding your medical information:

__________________________________ ___________________ ____________________

Name Phone Number Relationship

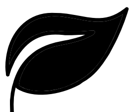
__________________________________ ___________________ ____________________

Name Phone Number Relationship

Emergency Contact Information:

__________________________________ ___________________ ____________________

Name Phone Number Relationship



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