



Pueblo
Community
Health Center

Chart # _____

Date _____

I, _____, give my permission to Pueblo Community Health Center and/or any other qualified staff member of Pueblo Community Health Center, to discuss my health care with the individuals noted below who may, from time-to-time, help me receive and pay for health care. This may include, but is not limited to, attending my appointments, helping me follow treatment recommendations, picking up medicines, helping me understand my test results, helping me understand and make payments for health care

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

I also would like Pueblo Community Health Center to follow these instructions when discussing my health care with the people I have identified above:

Signature of Patient

Date

Address

Date of Birth

You may end or change the directions in this form at any time by filling out a new form, or by notifying Pueblo Community Health Center in writing that you wish to do so.

Received By (Staff Signature): _____

Date: _____