INDIAN PEAKS MEDICAL GROUP

I, _____authorize the following
(PRINT NAME)
Person/persons to receive messages or results of tests performed on myself from the staff of Indian Peaks Medical Group.

_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship

The above persons may receive calls from Indian Peaks Medical Group in my name until I stipulate otherwise.

_____ I give my permission to leave messages on my answering machine.

_____	_____
Patient signature	Date
_____	_____
Witness	Date

14062 Denver West Pkwy • Bldg 52 • Suite 150 • Lakewood CO 80401
Phone: 303.893.8300 • Fax: 303.825.7927
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