CLEAR CREEK MEDICAL GROUP, PC

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

_____ _____
Print Name Relationship

_____ _____
Print Name Relationship

_____ _____
Print Name Relationship

The above persons may receive calls from Clear Creek 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

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Internal Medicine Hospitalists, Pulmonary, Critical Care, Sleep Medicine