Permission to Relay Information

Irvine Internal Medical Group, Inc.

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. We will not ask why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, ______________________________ give my permission to Irvine Internal Medical Group, Inc.
(Name of Patient)

physicians and employees information related to my health, as indicated below. This request supersedes any prior request for communication of information I may have made.

Phone

Contact me by telephone. **YES** ☐ **NO** ☐

If YES, I prefer to be reached on my: Home # ☐ Work # ☐ Cell # ☐

You may use the following telephone numbers:

Home ________________ Work ________________ Cell ________________

Leave messages on my answering machine/voice mail: YES ☐ NO ☐

You may leave messages with the following people:

________________________________ ________________________________

________________________________ ________________________________

Or

E-Mail

Contact me by secured e-mail (NextMD) YES ☐ NO ☐

Or

Mail

Send mail regarding appointments, test results, my condition and treatment YES ☐ NO ☐

Address ____

City/State/Zip ____

Signature: ______________________ Date: ____________ Date of Birth: ________

Print Name: ______________________ Relationship: ______________________

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