

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: _____



Irvine Internal Medical Group

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