Comprehensive
Care Center of Irvine
Patient Centered Healthcare

Permission to Relay Information

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 for Comprehensive Care Center of Irvine
(Print Name of Patient)
Physicians and employees to communicate information related to my personal health, as indicated below. This request supersedes any prior request for communication of information I may have made.

Phone

Contact me regarding my test results by telephone. YES ☐ NO ☐

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

You may use the following telephone numbers:

Work_____

Home_____

Cell Phone_____

You may leave messages regarding my medical information with the following people (Print Names):

1._____ 2. _____

3._____ 4. _____

E-Mail

Send e-mail messages by secured e-mail (Relay Health / NextMD) YES ☐ NO ☐

Mail

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

Address: _____

_____

Signature: _____ Date: _____ Date of Birth: _____
(Patient signature, if Patient is a minor then Parent or Legal Guardian must sign.)

Name: _____ Relationship: _____