INTERNAL MEDICINE PHYSICIANS, P.C.

CONTACT AUTHORIZATION

Name	Date of Birth

Internal Medicine Physicians, P.C. is committed to protecting our patient's privacy. Without your authorization, messages left on voicemail or with other individuals will be limited. The only information left will be limited to our office name and phone number. If you prefer more complete information be provided, please fill out the form below.

Please contact me as follows:

Best daytime contact #: ( ) _____

- ☐ Leave message – provider name/phone #
- ☐ Leave message – lab/test results, med changes

Any written communication will go to the address on file. Please verify we have your current address.

I hereby give permission to release my medical information to the following individuals:

- _____
- _____
- _____
- _____

Internal Medicine Physicians, P.C. Staff: changes in contact information may require system changes and documentation on a Privacy Practices Action Form (PPAF). Forms are available on the HIPAA form. This form does NOT replace those pages.

Please sign below to authorize the above contact information. Changes to this form will require a new form to be completed.

Sign:	Date: