

Internal Medicine Associates of San Mateo
100 S. Ellsworth Ave Ste 700
San Mateo, CA 94401
650-347-0063

Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

- I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to **(excluding healthcare professionals)**:
- Spouse _____
 - Child(ren) _____
 - Other _____
- Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Appointment Confirmation / Messages

- Please call: My home My work My cell
- E- mail: _____
- I would like to be enrolled in the NextMD Patient Portal where I can view upcoming appointments, request appointments and send secure messages to my Doctor.

If unable to reach me:

- You may leave a detailed message.
- Please leave a message asking me to return your call.
- _____

The best time to reach me is (Day) _____ between (Time) _____

Cancellation Policy

I understand I need to provide a 24 hour notice if I need to cancel or reschedule my appointment in order to avoid a fee of \$25 (office visit) or \$40 (physical) either with the office or the answering service (if after hours)

Signed: _____ Date: ____/____/____

Office use only:
Received by: _____ Date: ____/____/____