

Carmel Valley Internal Medicine
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Due to the HIPAA laws (Health Insurance Portability and Accountability Act of 1996), we ask that our patients sign this form allowing us permission to leave messages regarding your personal health, treatment or payment for treatment. This request is for communication channel purposes only and will be used solely for that purpose.

Please check/mark all that apply. Where you list more than one option, please indicate which one you prefer.

_____ I want Carmel Valley Internal Med. to contact me by telephone at (____) _____

_____ I want Carmel Valley Internal Med. to contact me by cell phone at (____) _____

_____ It is okay to phone me at work at (____) _____

_____ Carmel Valley Internal Medicine may leave messages on my answering machine.

_____ Carmel Valley Internal Medicine may leave messages on my cell phone voice mail.

_____ Carmel Valley Internal Medicine may leave messages with other family members (list below).

Please list the family members okay leave messages with: _____

_____ Carmel Valley Internal Medicine may NOT leave messages with any family members.

Comments: _____

Patient name: _____ Date: _____

Signature: _____