

**Andrew D. Smith, M.D., Inc.**  
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**PATIENT CONTACT PREFERENCE**

In accordance with Health Insurance and Portability Act (HIPAA) we are required to institute specific confidentiality safeguards regarding your medical health information. It will be necessary for our office staff to contact you regarding scheduled appointments, possible surgery scheduling, lab and other diagnostic test results and other related matters such as insurance coverage and billing.

Many people have multiple communication devices such as cell phones, work or home voice mail/answering machine systems. Consequently, we require specific instructions as to how best to contact you. In addition, if you wish other members of your household or other designated persons to be authorized to receive this protected health information, you must indicate those individuals that are authorized to be made aware of such information.

Please rank in order of preference all communication methods at which we may contact you to leave information about your appointment, surgical time or other related health information:

Home Telephone: (____) _____	1	2	3	(Circle)
Cell Phone: (____) _____	1	2	3	(Circle)
Work Phone: (____) _____	1	2	3	(Circle)
E-mail Address: _____	1	2	3	(Circle)

Would you like to be added to our E-mail list so that you can receive special offers and the latest information from our practice? Yes \_\_\_\_\_ No \_\_\_\_\_

If you are not available, may we leave information or instructions with a family member or other authorized person? Yes \_\_\_\_\_ No \_\_\_\_\_ (Initial)

Unless otherwise restricted, we will leave a message on your answering machine to contact our office.

Please PRINT the names and relationships of persons authorized to receive protected health information:

Name _____	Relationship _____
Name _____	Relationship _____
Signature of Patient, Parent or Guardian _____	Print Name of Patient _____

Date: \_\_\_\_\_  
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