Atef S. Zakhary, M.D.

HIPAA DISCLOSURE AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I have received a copy of Omni Medical Center for Women's notice of privacy practices. I understand that I may have a copy upon receipt.

_____ _____

Patient Signature or Legal Guardian Date

HIPAA RELEASE

Omni Medical Center for Women (OMC) and any employee thereof, is unable to discuss your treatment or medical condition with anyone unless you give us written permission.
I authorize OMC to disclose information including diagnosis, records, images, examination rendered, appointments and claim information to the following person(s):

_____ _____

Name Relation

_____ _____

Name Relation

_____ _____

Name Relation

MESSAGES

I authorize OMC to call my ( )Home ( )Work ( ) Cell Number: _____

If unable to reach me:

( ) You may leave a detailed message
( ) Please leave a message asking me to return your call
( ) Other _____

_____ _____

Patient Signature Date

706 W Platt St.
Tampa, FL 33606

6101 Webb Rd Ste. 102
Tampa, FL 33615

Ph.: 813-251-2000 www.omc4women.com **Fax: 813-283-6700**

Expires one year from date signed