PATIENT AUTHORIZATION FOR CONTACT & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name____**Date of birth**__________________

THIS FORM INSTRUCTS US WHO ELSE SHOULD GET YOUR MEDICAL INFORMATION.

I authorize Adel Zakhary, MD (practice) to disclose my protected health information to:
__________Family member(s) list____
__________Non-Family member(s) list____
__________Myself only

I authorize the practice to disclose only the following protected health information to the individuals listed above:
__________Test results, reports and general health updates
__________Nothing beyond general health questions and updates

WAYS OF CONTACT

I may be contacted with medical information at the following numbers:
Home #____________________________Cell #_____________________________
__________Please leave detailed message on my answering machine/voice mail
__________Please leave information with any individuals listed above
__________Please leave a message with only call back information on the answering machine or voicemail. Call back information will include doctor's name and staff member's name.
Work #____________________________
__________Please leave a detailed message on the answering machine/ voicemail
__________Please leave a message with only call back information on the answering machine or voicemail. Call back information will include doctor's name and staff member's name.

EXPIRATION OR TERMINATION OF AUTHORIZATION

This information will remain in effect until terminated by the patient or patient legal representative by submitting a written request to our office.

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PATIENT OR RESPONSIBLE PARTY'S SIGNATURE DATE