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.

_____ _____
PATIENT OR RESPONSIBLE PARTY'S SIGNATURE DATE