Atef S. Zakhary, M.D.

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

OMNI MEDICAL CENTER FOR WOMEN
706 W. PLATT STREET
TAMPA, FL 33606
P 813.251.2000 * f 813.283.6700

Patient Name: _____

Date of Birth: _____ Last four of SSN: _____

I authorize Omni Medical Center for Women (OMC) to:

( ) **OBTAIN** My Medical Records * ( ) **RELEASE** My Medical Records

NAME		PHONE	
ADDRESS		FAX	
CITY/STATE		ZIP	

TYPE OF INFORMATION TO BE RELEASED No information will be released until it is marked by initials of the patient or legal representative below.

_____General Medical Records excluding protected records (outlined below)

_____PROTECTED RECRODS: To include records including HIV/AIDS and other communicable disease information, Behavior Health, Alcohol and/or Drug abuse treatment.
_____OTHER: (please describe):_____

_____

By signing this agreement, I authorize OMC to obtain or release my Personal Health Information as indicated above.

_____ _____
Patient Signature or Legal Representative Date