*Atef S. Zakhary, M.D.*
*Jonathan Nutter, 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