Patient Authorization to Disclose Protected Health Information to Family/Provider of Care

I, _____, understand that Robert O. Zimmerman, M.D. and the office staff are authorized to disclose my protected health information by telephone or in person to the people that I have listed below.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____

☐ OK to leave message with detailed information ☐ Leave message with callback number only

☐ Work Telephone _____

☐ OK to leave message with detailed information ☐ Leave message with callback number only

☐ Written Communication

☐ Ok to mail to my home ☐ Ok to mail my home/office

☐ Ok to fax to this number _____

☐ Other _____

_____

Name(s) of person(s) authorized by this form to disclose my protected health information:

Name(s) & Relationship(s)	Allowed Information
_____	☐ Appointment ☐ Testing ☐ Medical ☐ Billing
_____	☐ Appointment ☐ Testing ☐ Medical ☐ Billing
_____	☐ Appointment ☐ Testing ☐ Medical ☐ Billing

I understand that I have the right to revoke anyone listed on the authorization and fill out the form before the revocation can be completed. This request must be done in writing.

All revocations must be sent to Robert O. Zimmerman, M.D. to the attention of the Privacy Officer and are not effective until received by the Privacy Officer.

I fully understand and accept the terms of this authorization.

Patient Signature _____ *Date* _____

FOR OFFICE USE ONLY

Authorization added to the patient's record on _____

Authorization verified by _____ on _____