Diplomate American Board of Internal Medicine Diplomate American Board of Cardiology

Nadim M. Zacca, M.D., F.A.C.C., P.A.
CARDIOVASCULAR DISEASE

PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, understand that Nadim M. Zacca M.D., P.A., is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operation. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipients of that information. I specifically authorize any current employee or owner of Nadim M. Zacca, M.D., P. A., or any other individual listed below to disclose my protected health information as described in this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclose by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

DESCRIPTION OF THE INFORMATION TO BE USED OR DISCLOSED:

☑ The patient's entire medical record. (Note: This requires explanation why the record may be disclosed.)

☐ The patient's demographic information. (Check all that are applicable.)

☐ Address ☐ State / Zip code only ☐Telephone ☐Age ☑Gender ☑Race Other _____

☐ Medical Data/Information related to: (Check all that are applicable.)

☐ Specific Conditions: _____

☑ Specific professional services: _____

☑ Specific medications: _____

☑ Other: _____

Names (s) or class of person (s) other than current employees or owners (s) authorized by this form to use or disclose the patient's protected health information:

_____

Names(s) or class of person(s) authorized by this form who may use and disclose health information:

_____

Purpose (s) of the information: _____

☑ (Check if applicable): This authorization is to be used for our own use and Nadim M. Zacca, M.D., P.A., will not discuss condition, testament, or payment or this authorization. Moreover, the patient has a right to inspect all copied information to be used or disclosed and may refuse to sign this authorization.

☐ (Check if applicable): This authorization permits Nadim M. Zacca, M.D., P.A., to send the protected health insurance information ONLY to this fax number or E-Mail: _____

Any other address, fax number or e-Mail is not permitted by this authorization. Th patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization, or if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Nadim M. Zacca, M.D., P.A., must receive the revocation in writing. The revocation must include:

- The patient's name, address and patient number if applicable.
- The effective date of this authorization, and the recipients of the protected health information according to this authorization.
- The patient's desire to revoke this authorization.
- The date of the revocation, and patient's signature.

Nadim M. Zacca, M.D., P.A., will accept written revocations of this authorization via:

- Certified U.S. Mail
- Facsimile at this number: (713) 795-5732

All revocations must be sent to Nadim M. Zacca, M.D. P.A., to the attention of Mrs. Nouha Zacca, Privacy Officer and does not affect until received by the Privacy Officer.

I fully understand and accept the terms of this authorizations.

_____ _____

Patient / Parent (If Minor) Date Signed

For Office Use Only

Authorization added to patient's medical record on: _____

Authorization verified by: _____ on _____