MICHAEL A. ZIMMER M.D., F.A.C.P
509 JACKSON ST N
ST PETERSBURG, FLORIDA 33705
PH 727-820-7800 FAX 727-820-7801

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I, _____ DATE OF BIRTH: _____
NAME (REQUIRED) (REQUIRED)

_____ DAYTIME PHONE: _____
ADDRESS (REQUIRED)
_____

_____
(SOCIAL SECURITY NUMBER)

AUTHORIZE RELEASE OF MY PROTECTED HEALTH INFORMATION (PHI) FROM:

NAME: _____ NAME: MICHAEL A. ZIMMER MD, FACP

ADDRESS: _____ TO: ADDRESS: 509 JACKSON ST NORTH

_____ ST.PETERSBURG FL 33705

THIS AUTHORIZATION EXPIRES: _____ (UNLESS OTHERWISE STATED, AUTHORIZATION EXPIRES SIX (6) MONTHS FROM DATE OF AUTHORIZED SIGNATURE)

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BUT THAT I MUST DO SO IN WRITING. THIS DOES NOT AFFECT RECORDS SENT OUT IN RELIANCE ON THIS AUTHORIZATION PRIOR TO RECEIVING THE REVOCATION REQUEST.

I WANT THE FOLLOWING INFORMATION TO BE DISCLOSED: (REQUIRED – PLEASE SPECIFY):
_____
_____

THE PURPOSE OF THIS DISCLOSURE IS: (REQUIRED – PLEASE SPECIFY):
_____
_____

PLEASE BE AWARE THAT INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION IS SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND IS NO LONGER PROTECTED BY THIS ORGANIZATION.

_____ DATE_____
SIGNATURE OF PATIENT OR REPRESENTATIVE (REQUIRED) (REQUIRED)

IF REPRESENTATIVE, AUTHORITY ON WHICH ACTING FOR THE PATIENT
_____

REQUIRED FIELDS MUST BE COMPLETED FOR RELEASE OF PROTECTED HEALTH INFORMATION

******PLEASE FORWARD THIS REQUEST TO YOUR PREVIOUS PHYSICIAN PRIOR TO YOUR APPOINTMENT WITH DR ZIMMER.***

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