Orlando Epilepsy Center

Records Release Authorization

Name of Patient	
Address	
Phone Number	E-mail
Birthdate	Social Security Number

Name of Guardian or Legal Representative	
Address	
Phone Number	E-mail

Orlando Epilepsy Center, following HIPAA guidelines, must act on the individual's request for access no later than 30 days from receipt of request.

If you are a Guardian/Legal Representative of the person whose information is to be disclosed, you must provide documentation proving your legal authority to request this information.

I hereby request that Orlando Epilepsy Center, Inc., release my medical records to the following (**check one**):
☐ all health information about me ☐ my medical records as described on the following page:

Person/Organization to Release Information		
Street Address		
City	State	Zip Code
Phone Number	Email	

Unless revoked earlier, this authorization will expire in 1 year from the date of signature.

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

Patient's Signature	**Patient's** Name	Date
Guardian or Legal Representative's Signature	**Guardian or Legal Representative's** Name	Date

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