ORLANDO EPILEPSY CENTER

RECORDS RELEASE AUTHORIZATION

Patient Name:

Address

Phone Number | E-mail

DOB MM/DD/YYYY | Social Security Number

Name of Guardian or Legal Representative

Address

Phone Number | E-mail

Orando 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 ☐ Other

Person/Organization to Release Information

Street Address

City | State | Zip Code

Phone Number | Email

Unless revoked earlier, this authorization will expire in 3 years 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