ORLANDO EPILEPSY CENTER

MEDICAL RECORDS REQUEST / RELEASE (To have records sent to Orlando Epilepsy Center from another Office)

OI E E

Patient name:		DOB	
Social Security # (last 4 digits)			
I authorize Orlando Epilepsy Center to r	request / release my health	information, from my physician:	
Physician/Practice Name:		Phone #:	
Address:		Fax:	
I authorize Orlando Epilepsy Center to r	request / release the follow	ing information:	
Labs Medication List Office	Notes Imaging Report	ts 🗋 Procedure Reports 🗋 All Re	cords 🗍 Other:
From:		0:	
I also understand that if a person or en federal privacy regulations, the infor regulations. However, the recipient ma or federal laws and regulations. I further understand that the person(s (either directly or indirectly) for doing s	mation described above r ay be prohibited from disclo s) l am authorizing to use	nay be re-disclosed and no longer osing my health information under ot	protected by these her applicable state
Signature of Patient		Date:	
Print Name of Representative)
Signature of Authorized Represe			
Updated 03/04/2024 - F20 - V2			
MONITORING UNIT LOCATIONS & 407 704 8380 407 704 8572 wntown 226 W Michigan St, Orlando FL 32806 r Phillips 6985 Wallace Rd, Orlando FL 32819	టి Downtown 2881 Del టి Clermont 805 Oakley టి Kissimmee 821 E Oa	& 407 652 6000 #407 203 3015 rcoossee Rd, Suite 112, Orlando FL 32832 laney Ave, Orlando FL 32806 y Seaver Dr, Suite 103, Clermont FL 34711 k St, Kissimmee, FL 34744 n) 1300 City View Center, Oviedo 32765	© © f y www.orlando-epile