WINTER PARK PRIMARY CARE

Neha Doshi, M.D.

942 LAKE BALDWIN LANE
ORLANDO, FLORIDA 32814
TEL: 321.285.6363
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AUTHORIZATION TO RELEASE/OBTAIN MEDICAL INFORMATION

______________________________ _________________________ ______________
Patient Printed Name   Social Security Number   Date of Birth

I hereby authorize the release my medical records TO/FROM Winter Park Primary Care, the office of Dr. Neha Doshi.

Provider's Name: ______________________________

Provider's Telephone: ______________________________

Provider's Fax: ______________________________

Please send the following records for the purpose of my continuity of care:

Office Notes   Lab Reports   Radiology Reports   Surgery Reports   Hospital Records   ALL RECORDS

Other: ____

I specifically consent to the release of any material in your possession, including, if any, existing results of HIV (AIDS) test and any which might address chemical dependence, depression, or other psycho-emotional issues. I understand that I do have the right to limit the release of this information at anytime by putting my request in writing. I request the provider named above promptly honor this request for medical information and/or copies of medical records. A copy of this request is as valid as the original. This authorization and request is valid for a period of one year from the date signed below, unless I request in writing to have this authorization revoked. I do, however, understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

PATIENT SIGNATURE**(X)**____DATE__________