FLORIDA NEUROLOGY AND EPILEPSY SPECIALISTS, PL.
6001 Vineland Road, Suite # 118, Orlando, FL 32819
Phone: (407) 792-5656 Fax: (407) 233- 1185

WELCOME TO OUR PRACTICE

We consider it a genuine privilege to serve you and thank you for choosing us to help you with your care. Our compassionate and skilled team is looking forward to working with you to address your medical needs.

In order to serve you best, please complete the new patient paperwork and consent of release of information. If you are health care proxy or power of attorney then please include a copy of power of attorney along with signed release of medical information form. Please arrive 15-20 minutes prior to your scheduled appointment time. Along with the completed new patient forms please bring the following current information with you to your visit:

- Medical Insurance Card(s)
- Driver's License or Photo ID
- Medication Bottles or Medication List

At your first visit, we will be taking the time to get to know you and your family. You will meet with Dr. Sharma.

We look forward to meeting you at our new office:

Florida Neurology & Epilepsy Specialists, PL
6001 Vineland Road, Orlando, FL 32819

Thank you and if you should have any questions please do not hesitate to call us at 407-792-5656 and we will be more than happy to help.

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Authorization To Obtain, Release or Review Protected Health Information

Patient Name: _____
Date of Birth: _____ Social Security#:_____
Phone #:_____ Identification Shown: _____

I herby authorize Dr. Umesh K Sharma, Florida Neurology and Epilepsy Specialists to Obtain, Review and Disclose Medical Records from:
Facility Name and Address: Neurology Faculty Practice Orlando Health
21 W. Columbia Street, Suite 200, Orlando FL 332806
OR Other Facility: _____
_____
_____

Please send the following information in my medical record regarding my hospitalization, care and treatment to Dr. Umesh Sharma at Florida Neurology and Epilepsy Specialists, PL
6001 Vineland Road, Suite # 118, Orlando, FL 32819.

___X_ Complete Record (Full Chart) ____ All Diagnostic Test Results
____ Pathology Reports
____ Abstract of Record ____ Consultation ____ Lab Only
____ Therapy Records ____ Radiology Only ____ Other:
____ Progress Notes ____ Operative Report _____

The purpose for the release of information at the request of the individual is:
____ Insurance **__X__ Continued Treatment** ____ Legal Action
____ Personal Use ____ Patient Communication (Behavioral Health)
____ Other:_____

I understand this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.
I DO NOT WANT TO INCLUDE INFORMATION RELEASED RELATED TO:
____ HIV/AIDS ____Mental Health ____Genetic Counseling
____Drug and/or Alcohol Abuse

If I fail to specify an expiration or event condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that this action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Dr. Umesh Sharma as well as Florida Neurology and Epilepsy Specialists may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of authorization. I understand the above information and I will receive a signed copy of this form:

Patient/Legal Representative Signature Date

**** If you are legal guardian or power of attorney for the patient then please include copy of the power of attorney along with this document.**