Neeraj Sharma, MD
Gregory L. Ortega MD
Santosh Nair MD
Seema Harichand-Herdt, MD
Giselle Mery, MD
Lynn Coleman, PA

MID FLORIDA CANCER CENTERS
Caring For Your Life

Rene Cabeza, MD
Bhanu Visvalingam, MD
Gary Graham, MD
Roderick Paras, MD
Dipali Trivedi, MD
Kathleen Tabaka, ARNP

PATIENT DISCLOSURE TO REQUEST RECORDS FROM OTHER PROVIDERS

PATIENT NAME: _____ DATE: _____

DOB:_____ SOCIAL SECURITY#_____

Purpose of Disclosure:

_____ Continuing care with another physician or hospital _____ Personal copy

_____ Other: _____

I AUTHORIZE THE FOLLOWING PHYSICIAN(S), PHARMACY(S) AND/OR HOSPITAL(S) TO RELEASE MY MEDICAL RECORDS IN THEIR ENTIRETY OR AS INSTRUCTED BELOW TO: MID FLORIDA HEMATOLOGY AND ONCOLOGY CENTERS, PA / MID FLORIDA CANCER CENTERS

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PLEASE FAX RECORDS TO 386-774-1314

I understand that:

1. This authorization will remain in effect for 365 days
2. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.
3. I may refuse to sign this authorization and that it is strictly voluntary.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. If I do not sign this form, my health care and the payment for my health care will not be affected.
6. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, or if I ask for it.
7. I will receive a copy of this form after I sign it.

Patient Signature:_____ Date: _____

RepresentativeSignature:_____ Date:_____

Relationship to Patient: _____

Witness Signature: _____ Date: _____