Tasmina Sheikh, M.D., P.A.

Diplomate of the American Board of Psychiatry and Neurology
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RELEASE/REQUEST OF INFORMATION

*Having properly created and preserved a medical record, **a physician must ensure the record remains confidential**. Section 456.057(5), Florida Statutes. Nevertheless, the physician must, upon request, furnish the patient or its legal representative with a copy of "all reports and records relating to [the patient's] examination or treatment…)other than AIDS, mental, and substance abuse records.)," although a psychiatrist or psychologist may substitute a report of the examination in lieu of the medical record. Section 456.057(4), Florida Statutes. Medical records of a psychiatric nature will not be given to patients under any circumstance, unless approved by Dr. Tasmina Sheikh, MD, PA.

PATIENT NAME:____

I GRANT PERMISSION FOR THE RELEASE / REQUEST OF ALL MEDICAL RECORDS INCUDING LABS, NOTES, TESTS, ETC… (CHECK ALL THAT APPLY)

COPIES OF PATIENT MEDICAL RECORDS MAY BE FORWARDED TO:
(I.E. MEDICAL DOCTOR, THERAPIST, LAW OFFICE)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

COPIES OF PATIENT MEDICAL RECORDS MAY BE REQUESTED FROM:
(I.E. MEDICAL DOCTOR, THERAPIST, PAST PSYCHIATRIC RECORDS)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

INFORMATION REGARDING PATIENT CASE MAY BE DISCLOSED TO:
(I.E. EMERGENCY CONTACT)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

I authorize the office of Tasmina Sheikh, MD, PA to confirm (my/the patient's) scheduled appointments in the following manner: Home, cell or work phone, answering machine, voicemail box, or email. _______*initial here*

I authorize the office of Tasmina Sheikh, MD, PA to inquire about or share (my/the patient's) medication information to the preferred pharmacy on file on (my/the patient's) behalf. ________*initial here*

HIPAA COMPLIANCE NOTICE: I acknowledge that I have been informed of the HIPAA compliant regulations and I am fully aware of my rights with regard to the protection of my medical records and other pertinent information pertaining to my medical care.

Patient/Legal Guardian Signature:______________________________ Date:______________
Printed Name:____________________________ Relationship to Patient:__________________
Witness: ______________________________