Tasmina Sheikh, MD PA

Diplomate of the American Board of Psychology and Neurology
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Release/Request of Information Consent

*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 it's 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 circumstances, unless approved by Dr. Tasmina Sheikh, MD, PA.

PATIENT NAME_____

I GRANT PERMISSION FOR THE RELEASE/REQUEST OF ALL MEDICAL RECORDS INCLUDING LABS, TESTS, REPORTS OF EXAMINATION, ETC… COPIES OF MY MEDICAL RECORDS MAY BE FORWARDED TO OR REQUESTED FROM THE FOLLOWING:
(i.e. Medical Doctor, Therapist, Law Office)

_____ _____

_____ _____

_____ _____

_____ _____

INFORMATION REGARDING MY CASE AND TREATMENT MAY BE DISCLOSED TO/DISCUSSED WITH:
(i.e. Family Member, Friend, Emergency Contact)

_____ _____

_____ _____

_____ _____

_____ _____

I authorize the office of Tasmina Sheikh, MD PA to confirm all scheduled appointments in the following manner: HOME/CELL PHONE, VOICEMAIL, AND/OR EMAIL. _____*initial*

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

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 PRINTED Name: _____

Patient/Legal Guardian SIGNATURE: _____DATE: _____

Witness Signature: _____