



Deepak Raja, M.D.
Keshini C. Parbhu, M.D.
4750 The Grove Drive
Orlando, FL 32819
(P) 407-704-3937 (F) 407-704-3920

AUTHORIZATION TO REQUEST OR RELEASE MEDICAL INFORMATION

PATIENT:

LAST NAME FIRST NAME

I AUTHORIZE:

HEALTHCARE PROVIDER

ADDRESS

CITY STATE ZIP CODE

TO RELEASE TO:

NAME OF RECEIPT

ADDRESS

CITY STATE ZIP CODE

I AM REQUESTING COPIES OF THE FOLLOWING INFORMATION FROM MY MEDICAL RECORD: (Please check box below)

- COMPLETE MEDICAL RECORD
X-RAY/ LABORATORY TEST (SPECIFY):
RECORDS PERTINENT ONLY TO MY ILLNESS:
HISTORY AND PHYSICAL EXAM (DATE):
OTHER:
HIV RECORDS
MENTAL HEALTH
ALCOHOL/SUBSTANCE ABUSE RECORDS

Orlando Eye Institute is hereby released from all legal liability that may arise from the release of the information requested. I understand that this information is to be disclosed for the following purpose and that purpose only.

This authorization shall expire 60 days from the date below. It may be revoked in writing at anytime.

Patient Signature: DATE:

ADDRESS DOB:

CITY STATE ZIP CODE