

RECORDS TRANSFER REQUEST

SEND TO _____ REQUEST FROM _____ PICK-UP _____ FAX TO # _____

LOCATION NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

I HEREBY AUTHORIZE THE RELEASE OF COPIES OF MY RECORDS FROM _____ to _____
AND REQUEST THAT THEY BE: ***TRANSFERED TO / RELEASED FROM:***

BRAVERMAN EYE CENTER

TELEPHONE 954-458-2112 • FAX 954-458-7186
1935 E. HALLANDALE BEACH BLVD.
HALLANDALE BEACH, FLORIDA 33009

ATTN:

___ STANLEY BRAVERMAN, M.D., F.A.C.S.

___ ALAN LANE, M.D.

___ ERIC CILIBERTI, M.D.

___ KEVIN STEWART M.D., F.A.C.S.

___ RYAN HARGREAVES, O.D.

___ DAVID TENZEL, M.D., F.A.C.S.

___ TIRSO LARA M.D., F.A.C.S.

___ RASHID TAHER M.D., F.A.C.S.

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with continued patient care. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information:

PRINT NAME OF PATIENT. _____ D.O.B. _____

SIGNATURE OF PT./GUARDIAN: _____

WITNESS: _____ DATE MAILED: _____