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
1050 NORTH FEDERAL HIGHWAY
HOLLYWOOD, FLORIDA 33020

ATTN:

_____STANLEY BRAVERMAN, M.D., F.A.C.S.
_____ERIC CILIBERTI, M.D., M.S.
_____RYAN HARGREAVES, O.D.
_____TIRSO LARA, M.D., F.A.C.S.
_____ALAN LANE, M.D., F.A.C.S.
_____AARUP KUBAL, M.D., F.A.C.S.
_____JESSE PELLETIER, M.D., F.A.C.S.
_____ANDRÉS SÁRRAGA, 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_____