

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 *TRANSFERRED 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. ____ TIRSO LARA, M.D., F.A.C.S. ____ JESSE PELLETIER, M.D., F.A.C.S.
____ ERIC CILIBERTI, M.D., M.S. ____ ALAN LANE, M.D., F.A.C.S. ____ ANDRÉS SÁRRAGA, M.D., F.A.C.S.
____ RYAN HARGREAVES, O.D. ____ AARUP KUBAL, 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 _____