AUTHORIZATION TO TRANSFER MEDICAL RECORDS

I hereby authorize (former M.D./Specialist)_______________________________________M.D.

Address: ____

City:____________________________________ State: ______ Zip Code:__________________

Phone number: _______________________ Fax number: ________________________

To furnish medical information concerning patient:

PRINT NAME:____

DATE OF BIRTH: _______________________________ To physician's name and address below.

Rupesh R. Dharia, M.D.

Board Certified Internal Medicine

Palm Beach Internal Medicine

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Tel: 561-776-8891 Fax: 866-436-2183

**** <u>MOST RECENT</u>** MEDICAL RECORDS, LABS, TEST RESULTS, SCANS, IMAGES, EKG'S, ETC.**

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This authorization is effective now and will remain in effect until (Date): ___________________
I understand that I may receive a copy of this authorization.

Signature: ___________________________________ Date: ____________________

If not signed by the patient, please indicate relationship:

______ Parent or Guardian of minor patient.
______ Guardian or conservator of an incompetent patient.
______ Beneficiary of personal representative of deceased, patient.