**AUTHORIZATION TO TRANSFER MEDICAL RECORDS FROM**

**Palm Beach Internal Medicine**

**Rupesh R. Dharia, M.D.**

**Brianne Duffy, APRN Melissa Dail, APRN Katie Kuretski, DNP, APRN**

3502 Kyoto Gardens Dr, Suite A

Palm Beach Gardens, FL 33410

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

I authorize **Palm Beach Internal Medicine** to furnish medical information concerning:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ To Physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any and all information may be released, including, but not limited to mental health records protected by the Lanterman-Petris-Short Act, drug and alcohol abuse records and HIV test results, if any, except as specifically provided below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization is effective now and will remain in effect until \_\_\_\_\_\_\_\_\_\_\_\_\_.

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.