AUTHORIZATION TO TRENSFER MEDICAL RECORDS

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

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

To furnish medical information concerning patient:

PRINT NAME: _____

D.O.B: _____ To physician's name and address below.

JUPITER LAKES PHYSICIAN GROUP, PA

-INTERNAL MEDICINE-

BAQIR SYED M.D. * CHRIS HAMPER PA-C

210 JUPITER LAKES BLVD BUILDING 4000 SUITE 202, JUPITER FL 33458

TEL: 561-744-3467 * FAX: 561-748-3272

**** MOST RECENT** MEDICAL RECORDS, LABS, TEST, RESULTS, SCANS, IMANGING, EKG'S, ETC.**

This authorization is effective now and will remain in effect until (Date): _____

Signature: _____ Date: _____

If not signed by the patient, please indicate relationship:

_____ Parent or Guardian of minor patient.

_____ Guardian or conservator of an incompetent patient