Gardens Neurology

AUTHORIZATION TO TRANSFER MEDICAL RECORDS

I hereby authorize the hospital (name of hospital) _____

or office of Dr. _____

Address:_____

City:_____State:_____Zip:_____

Phone:_____Fax:_____

To furnish all medical information concerning patient:

Please print name:_____

Date of birth:_____to Dr. Silvers at

Gardens Neurology

3401 PGA Blvd.

Suite 440

Palm Beach Gardens, FL 33410

Phone (561)799-2831 Fax (561) 429-3184

Pertaining to most recent medical notes, labs, test results, scans, images, ETC.

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

I understand that I may receive a copy of this authorization.

Patient signature_____Date_____

For guardians, please sign, print name and indicate relationship to patient:

_____