Authorization for Transfer of Medical Records

I hereby certify that (M.D/Specialist/facility) _____

Address:

_____

_____

Phone: _____ Fax: _____

To furnish medical information concerning patient:

Name: _____ D.O.B: _____

To the physician the following physician:

Baqir Syed M.D. Internal Medicine (PCP)

210 Jupiter Lakes Blvd Building 4000 Suite 202 Jupiter Fl, 33458

Ph: 561-744-3467 Fax: 561-748-3272

- **Most recent- medical records, labs, test results, scans, imaging, ekg, etc.**
- _____
  _____

Signature: _____ **Date:** _____