Authority to transfer patient records

Patient Name: _____

DOB: _____

Address: _____

I _____ (parent / guardian, or patient if over 18 years old)

Give authority for Dr Domenic Cincotta to transfer a copy of my medical record to:

Dr _____

Address _____

Email _____

I authorise the record to be sent by email using end-to-end encryption, or with a password protected document (circle) Yes / No

Patient / guardian signature _____

Phone _____

Email _____

Date _____