SHORE ORTHOPAEDIC UNIVERSITY ASSOCIATES

Authorization To Release Medical Records

Request for Transfer of Medical Records

From: _____

To: Shore Orthopaedic University Associates

Patient:

Name: _____ DOB _____ Phone: _____

Address: _____

PATIENT AUTHORIZATION:

Specify information & dates to be released: _____

_____

I hereby authorize information in my medical records to be released.

I authorize: _____ to transfer my records.

Patient Signature: _____ Date: _____

(Patient, Guardian or Authorized Representative)

*__NOTE:__ Please do not fax patient files over 5 pages. Larger files can be emailed to: medicalrecords@shoreorthodocs.com

SHORE ORTHOPAEDIC UNIVERSITY ASSOCIATES
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24 MacArthur Blvd, Somers Point, NJ 08244
medicalrecords@shoreorthodocs.com
609-927-1991 EXT. 301
Fax: 609-904-2480