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)

SHORE ORTHOPAEDIC UNIVERSITY ASSOCIATES
Medical Records Department
24 MacArthur Blvd, Somers Point, NJ 08244
609-927-1991 EXT. 301
Fax: 609-904-2480