



# 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](mailto:medicalrecords@shoreorthodocs.com)

SHORE ORTHOPAEDIC UNIVERSITY ASSOCIATES  
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medicalrecords@shoreorthodocs.com  
609-927-1991 EXT. 301  
**Fax: 609-904-2480**