AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby request South Mountain Orthopaedic Associates, LLC., located at 61 First Street, South Orange, NJ 07079 to release my medical records.

Specific records you are requesting & include dates of treatment, if applicable:

_____

_____

_____

If this request is for specific records to be faxed to another physician, please include the doctor's name, address, fax number and telephone number:

_____

_____

If you require your medical information for several recipients, we suggest obtaining the records and forward them accordingly.

PRINT PATIENT'S NAME:_____Date of Birth:_____
Address:_____

Telephone Numbers:_____

- ***I understand that fees may be involved for copies and agree to pay for any applicable fee in advance.***

PATIENT'S SIGNATURE: X_____
Date of this request_____