BAYSIDE ORTHOPEDIC, LLC
Office of Erik S. Larsen, D.O.
780 Route 37 West Suite 330
Toms River, NJ 08755
Phone (732) 966 6317 Fax (732) 998 8086

RECORD RELEASE AUTHORIZATION

Date:_____

To: _____

Patient Name:_____ Date of Birth:_____/_____/_____

Address:_____

_____

Initial

_____I verify I am accepting my medical records and will be responsible for issuing said records in the future to all requesting parties.

_____I will be transferring my care to another physician.

_____Please forward all orthopedic related records to our office.

_____Please forward all of the records requested below to our office:

_____

_____

_____Please forward my records to the facility/company/individual (include address) listed below:

_____

_____

_____Please fax the records to (732) 998 8086 _____

I authorize a copy of this release to be used in the place of an original. I also understand I have the right to revoke this authorization except to the extent the action has already been taken in reliance of the authorization. The information disclosed may contain personal data that might be otherwise restricted for release. This authorization will be in effect until seven years after the last date of treatment or until it is revoked by either party. I understand once the information is disclosed to a third party, they may in turn disclose it to someone else and they may not be a covered entity under the Health Insurance Portability and Accountability Act.

SIGNATURE_____DATE_____

If signed by patient representative, state relationship:_____