



BAYSIDE ORTHOPEDIC, LLC

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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: _____

This facsimile transmission is intended only for the addressee named above. It contains information that is privileged, confidential or otherwise protected from use and disclosure, copying or dissemination of contents, or other use is strictly prohibited. If you have received this transmission in error, please notify us by telephone immediately so that we can arrange for its return to us. Thank you for your cooperation.