

SPINE & ORTHOPEDIC CENTER OF N.J., LLC

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DAVID B. BASCH, M.D., FAAOS
Fellow American Academy of Orthopedic Surgeons
Diplomat American Board of Orthopedic Surgery

AUTHORIZATION TO RELEASE RECORDS

Patient's Name _____

Address _____

I hereby authorize _____

To disclose to

DAVID B. BASCH, M.D.
Spine & Orthopedic Center of New Jersey
90 Sparta Avenue
Sparta, New Jersey 07871

The complete medical history records in your possession, concerning my illness, treatment and/or evaluation during the period from ____/____/____ to ____/____/____.

PATIENT'S SIGNATURE

TODAY'S DATE