CAPITAL WOMEN'S CARE
Working Together for Women's Health

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AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION *TO* CAPITAL WOMEN'S CARE

Patient Name: _____ Acct.# _____

Former Name (if any)_____ SS. # _____

Daytime Telephone _____Birth date_____/_____/_____ email _____

INFORMATION TO BE RELEASED FROM:

I hereby authorize _____ (NAME OF OTHER PROVIDER RELEASING INFORMATION) to use and disclose my individually identifiable Protected Health Information (PHI) in the manner described below. I understand that my PHI may be redisclosed by the person or entity receiving my PHI from the above named provider, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI from the above named provider. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

PROTECTED HEALTH INFORMATION TO BE RELEASED TO:

Capital Women's Care 10801 Lockwood Dr # 320 Silver Spring, MD 20901 301.681.3400

Purpose or need for this information is: _____

TYPE OF INFORMATION TO BE RELEASED:

1. GENERAL RELEASE:

Type of Record

___ Medical Records/Excluding Protected Records
(This will be limited to 2 years of information including x-ray, Lab reports unless otherwise stated).
___ Lab Results (specify)_____
___ X-ray Reports (specify)_____
___ Surgical records (specify)_____
___ Other Records (specify)_____

2. INFORMATION PROTECTED BY STATE/FEDERAL LAW:

___ Drug Abuse Diagnosis/Treatment (specify) _____
___ Mental Health Diagnosis/Treatment (specify) _____
___ Sexually Transmitted Disease (specify) _____
Diagnosis/Treatment or Counseling (includes Aids/HIV) (specify) _____

I understand that I have the right to receive a copy of this authorization. I also understand this authorization is valid for 90 days only and may be revoked in writing at any time prior by notifying _____ (Name of Entity Releasing Information) in writing.
I understand I have the right to revoke the authorization at any time except to the extent that action has been taken in reliance thereon.

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ X_____ _____
Date Signature of Patient/ Relationship to
Legally Responsible Party Patient if not Patient

REV 11/2016