CAPITAL WOMEN'S CARE
Working Together for Women's Health
OB & GYN Center Division

97 Thomas Johnson Dr. #101
Frederick, MD 21702
P: 301-663-4545
F: 301-663-1709

AUTHORIZATION TO RELEASE MEDICAL RECORDS FROM CAPITAL WOMEN'S CARE

Patient Name: ____ MR#: _________________________

Former Name (if any): ____________________________________ SS#: __________________________

Daytime #: ____________________________ Birth Date: ______/______/________

INFORMATION TO BE RELEASED FROM:

I hereby authorize Capital Women's Care (CWC) 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 CWC, 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 CWC. 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:

Name of Facility: ____

Address: ____

____

Phone and Fax Number: ________________________/__________________________

TYPE OF INFORMATION TO BE RELEASED:

____ Most Recent Pap Smear ____ Most Recent Mammogram

____ Medical Records (this will be limited to 2 years of information to include office notes, x-rays, lab reports)

____ Lab Results (specify) ___________________________________

____ X-Ray Reports (specify) _________________________________

____ Surgical Records (specify) ______________________________

____ Other Records (specify) ________________________________

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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 Capital Women's Care 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.

X____ _________________ _____________

Signature of Patient/Legal Guardian Relationship to Patient Date

Note: *Maryland State Law permits a fee to be charged for copying/transferring of records.*

CWC Use only: Total Fee: ____________ Internal Processing: ________ External Processing: _________
Date Received Request: _____________ Date Mailed/Faxed/Patient picked up from office___________