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 INFORMATION TO CAPITAL WOMEN'S CARE

Patient Name: ____ MR#: _________________________

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

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

INFORMATION TO BE RELEASED FROM:

I hereby authorize ____ (*name of 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 disclosure 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.

Address of Facility Releasing Information:

____

Phone and Fax Number of Facility Releasing Information:

______________________________/______________________________

PROTECTED HEALTH INFORMATION TO BE RELEASED TO:

Capital Women's Care, OB & GYN Center Division
97 Thomas Johnson Drive, Suite 101, Frederick, MD 21702
Phone number: 301-663-4545 Fax number: 301-663-1709

TYPE OF INFORMATION TO BE RELEASED:

____ 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 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