CAPITAL WOMEN'S CARE

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CONSENT FOR USE AND DISCLOSURE OF INFORMATION

By signing below, you consent to Capital Women's Care use and disclosure of protected health information about you for the release of any information acquired in the course of any treatment necessary to process the attached form.

I further authorized a copy of this authorization to be used in place of the original.

**** Please understand that we can only authorize days that are MEDICALLY necessary. ****

There is a $15.00 administrative fee **PER EACH SET** of disability forms that need to be completed for your upcoming procedure. Payment is due when forms are turned in.

There is a 1 week turn around time for forms to be completed.

Patient section MUST be FULLY COMPLETED in order for office to fill out.

TO BE COMPLETED BY PATIENT:

Patients Name: _____ DOB: _____

Signature: _____ Contact Info:_____

Check what would you like to do be done with forms:

Pick Up: When ready or Next Visit Email:_____

Fax To: _____ Att: _____

Mail To: _____

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for office use only:

Paid by: Cash or Credit Card: VISA, MC, DISCOVER, AMEX or check #:_____ Init:_____

Forms Completed on: _____ Forms were: _____ Init.:_____

Other:_____