Capital Women's Care – Division 22
Band, Tyau, Sine, Resta, Lizardo, Shrout & Hersh

CONSENT FOR USE AND DISCLOSURE OF INFORMATION

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

There is a **$20.00 administrative fee per each set of disability forms** that need to be completed for your upcoming procedure. Payment is due at the time the form(s) are submitted to our office. Please allow 1week for forms to be completed.

Forms will NOT be completed until payment is received and the patient section below is completed.

By signing below, I authorize Capital Women's Care to use and disclose my individually identifiable Protected Health Information necessary to process the attached form.
I further authorize a copy of this authorization to be used in place of the original.

TO BE COMPLETED BY PATIENT:

Date:_____ Patient Name: _____ DOB: _____

Signature: _____ Contact Info:_____

Reason for form:_____

Please indicate how you wish to receive your completed forms (Select 1):

Pick Up: When ready OR Next Visit

Fax To: _____ Attn: _____

Mail To: _____

****

For Office Use Only:

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

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

Other:_____