CAPITAL WOMEN'S CARE

DIVISION 22
Silver Spring Office
10313 Georgia Avenue, Suite 202
Silver Spring, MD 20902
Rockville Office
15225 Shady Grove Road, Suite 306
Rockville, MD 20850
Phone: 301-681-9101 Fax: 301-681-3525

# 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 for *each set* of requested form** that needs to be completed.
Payment is due at the time the request is submitted to our office. Please allow 2 weeks 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 One):**

**Pick Up**: When ready OR Next Visit
**Fax** To: _____ Attn: _____

**Mail** To: _____

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**For Office Use Only:**

Paid by: Cash Credit Card Check #:_____ Init:_____

Forms Completed on: _____ Forms were: Mailed Faxed Picked Up Init.:_____

Other: _____