Capital Women's Care – Division 22

Band, Lizardo, Resta, Shrout, Sine, Lin, Footer, Wagar, Vignali, NP Lefkof

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 Tel: _____

Reason for form: _____Obstetrics _____GYN/Surgery

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

____**Fax** To: _____ Attn: _____

____**Mail** To: _____

____**Send** through portal

____**Pick up** in office ____Silver Spring ____Rockville

****

For Office Use Only:

Paid by: ___**Cash**

___**Credit Card:** VISA, MC, DISCOVER, AMEX

___**Check #**:_____ Init:_____

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