CAPITAL WOMEN'S CARE

FAX records to 301.869.5793

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION
PATIENT INFORMATION TO CAPITAL WOMEN'S CARE

Patient Name: _____ Acct.# _____

Former Name (if any)_____ SS. # _____

Daytime Telephone _____ Birth date_____/_____/_____

INFORMATION TO BE RELEASED FROM:

I hereby authorize _____ (NAME OF OTHER 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 redisclosure 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.

PROTECTED HEALTH INFORMATION TO BE RELEASED TO:

Name of Organization — Site Location:22B — Street Address: 15001 Shady Grove Rd., Suite 200 — City/State/Zip: Rockville, MD 20850

Capital Women's Care — Dr's Band, Sine, Resta, Lizardo, Lin, Shrout, Footer, Wagar, Vignali and NP Lefkof

Purpose or need for this information is: _____

TYPE OF INFORMATION TO BE RELEASED:

1. GENERAL RELEASE:

Type of Record

___Medical Records/Excluding Protected Records
(This will be limited to 2 years of information including x-ray, Lab reports unless otherwise stated).
___Lab Results (specify)_____
___X-ray Reports (specify)_____
___Surgical records (specify)_____
___Other Records (specify)_____

2. INFORMATION PROTECTED BY STATE/FEDERAL LAW:

___Drug Abuse Diagnosis/Treatment (specify) _____
___Alcoholism Diagnosis/Treatment (specify) _____
___Mental Health Diagnosis/Treatment (specify) _____
___Sexually Transmitted Disease (specify) _____
Diagnosis/Treatment or Counseling (includes Aids/HIV) (specify) _____

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 _____ (Name of Entity Releasing Information) 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.

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ X_____ _____

Date — Signature of Patient/ Legally Responsible Party — Relationship to Patient if not Patient