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AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION TO CWC

PATIENT INFORMATION

Patient Name Acct #
Former Name (if applicable) SS #
Daytime Telephone # Date of Birth

INFORMATION TO BE RELEASED FROM

I hereby authorize (Name of Other Provider Realizing Information) to use and disclose my individually identifiable Protected Health Information (PHI) in the manner described below.

PROTECTED HEALTH INFORMATION TO BE RELEASED TO

Capital Women's Care/Dr. Gurdian and Associates
9711 Medical Center Drive, Suite 109
Rockville, Maryland 20850

Purpose or need for this information is

TYPE OF INFORMATION TO BE RELEASED

General Release

Type of Record to be Released (please check all that apply)

- Medical Records/Excluding Protected Records
Lab Results (specify)
X-ray Reports (specify)
Surgical Records (specify)
Other Records (specify)

Information Protected by State/Federal Laws

- 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 CWC in writing.

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that I have read, signed and received a copy of this authorization upon my request. I understand I will be billed for copies of my medical record according to HIPAA State of Maryland and Federal laws.

Date Signature of Patient/Legally Responsible Party Relationship to Patient

FOR OFFICE USE ONLY
Date Received Date Completed Signed
Notes