AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
**PLEASE COMPLETE ALL SECTIONS OF THE RELEASE OF YOUR MEDICAL RECORDS.
IF YOU HAVE ANY QUESTION, PLEASE ASK THE FRONT DESK.

Name of Patient: * _____ Soc. Security #: * _____
Address: _____ Phone Number: _____
_____ Date of Birth: * _____

1. **I hereby request that CAPITOL MEDICAL GROUP Provide the following PHI and process thru:**
   - ❑ CAPITOL MEDICAL GROUP
     8401 Connecticut Ave. Suite # 201
     Chevy Chase, MD 20815
     Phone: 301-907-3960
     Fax: 301-652-4933
     www.capitolmedicalgroup.com

2. **Include PHI Date Range to be Released** (include date range of discharge, service, etc.) _____
3. **Description of PHI to be Release: (Check ALL that apply)**

   - ❑ Entire Medical Record
   - ❑ History and Physical
   - ❑ Progress Notes
   - ❑ Labs
   - ❑ Pathology Reports
   - ❑ Operative Reports
   - ❑ Other (Specify) _____

   Transfer To New Practice
   * CIRCLE ONE: YES/ NO

4. **If Applicable, Please Check Specific Confidential PHI Authorized for This Release Listed Below:**
   By signing my initials next to the specific category of highly confidential PHI, I am authorizing **CAPITOL MEDICAL GROUP** to release the indicated type of information next to my initials pursuant to this Authorization from the treatment date(s) listed above.

   - ❑ HIV/AID Related Information
   - ❑ Mental Health & Psychotherapy Information
   - ❑ Drug and Alcohol Information
   - ❑ Sexually Transmitted Disease Information
   - ❑ Genetic Information
   - ❑ Tuberculosis

   Reason for leaving: _____

1 I understand that payment is required before records are mailed or picked up

5. Please Mail records to:

_____
_____
_____

THIS IS A PATIENT REQUEST: THE PATIENT WILL BE CHARGED FOR THE MEDICAL RECORD UNLESS OTHERWISE NOTED* FEE: **$30.00 per child for a CD.**

I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. I understand that I am not required to sign this authorization and that this consent may be revoke in writing at any time. With the exception to the extent that disclosure of PHI has already occurred prior to the receipt of revocation by the named provider. To initiate revocation of this authorization a direct written correspondence must be sent to the health care provider above. Within 30 days from the request.

I certify that I have read, signed and received a copy of this authorization upon my request

_____ _____ _____
Signature Date Relationship to patient