Bruce S. Rashbaum, M.D
Medical Director

Theo Hodge, M.D.
Mary Alder, N.P
Richard Elion, M.D.

Capital Medical Associates, P.C.

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____ **Date:** _____
From (patient name): _____ **DOB:** _____

I voluntary authorize and direct my health care provider **(Please insert provider name)** _____ _____to release, disclose, and deliver my health information during the term of this Authorization only for the purposes and parties also described below. Please complete entirety of form to expedite.

Specific information to be disclosed (Check all that apply):

___ Doctor's notes
___ Pathology/Cytology reports
___ Outside Consult
___ Laboratory Results
___ MRI reports
___ Other Radiology reports
___ Hospital Reports
___ Other:_____

Recipient of the records:

___ Capital Medical Associates, P.C. (circle one)
(Dr. Bruce Rashbaum, Dr. Theo Hodge, Mary Beth Alder, Ph.D, CANP)
___ Myself
___ Doctor/Facility, list name and address: _____
_____

___ Other, list person(s): _____

Method of delivery:

___ Mail /Fax to (list address / fax #): _____
___ Pick up in Office

Purpose of the request:

___ Change of residence / location
___ Change of insurance
___ Medical Treatment
___ Other (specify): _____

Expiration Date: Authorization expires 6 months from date signed unless indicated differently:
_____

I understand that by my signature I hereby release Capital Medical Associates, P.C. from any liability if the above reference documents are lost, not returned to Capital Medical Associates, P.C. or used by other parties. I also acknowledge that there may be a processing fee collected prior to release of my records.

_____ _____
Print Name Relationship if Personal Representative

_____ _____
Signature Date

_____
Physician's Approval