Capital Area Physician Weight & Wellness Center
124 Park Street Southeast, Suite 203, Vienna, VA 22180
44121 Harry Byrd Highway, Suite 250, Ashburn, VA 20147
Ph: 703.255.6010 Fax: 703.255.6011
www.capwwc.com

AUTHORIZATION FORM FOR MEDICAL RECORDS

_____ _____
(Patient's Full Name) (Birth Date (MM/DD/YYYY)

_____ _____
(Street Address) (Social Security Number)

_____ _____
(City, State, Zip Code) Tel # Primary / Cell Phone

At the request of the individual, I _____ do hereby authorize:
(Patient's Name)

I hereby authorize: Dr. Sree Gogineni, MD, CAPWWC Tel# 703-255-6010 Fax# 703-255-6011

To release Medical Records To:

Dr. /Facility_____

Address: _____

Tel: _____ Fax_____

To Obtain Medical Records From:

Dr. /Facility_____

Address: _____

Tel: _____ Fax: _____

□ Complete Records □ Medication List □ Lab Results □Radiology Studies □ Specialist Consults □Statement

□ECG/Cardiac □ Hospital Records □ Operative Reports □ Itemized Billing □ other (Specify) _____

_____ I DO _____ I DO NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Purpose of Disclosure:

□ Disability Determination □ Legal Investigation □ Change of Doctor □Referral to Specialist □Workers Comp

□Continuing Care □ Personal □ Other (Specify) _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of Individual/Guardian/ Personal/ Representative of Patient's Estate **DATE (MM/DD/YYYY)**

NOTE: There will be a charge for the complete, permanent transfer of your records to another facility. Charges will be determined by the number of pages.