# Capital Area Physician Weight & Wellness Center

**Sree L. Gogineni, MD**

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## 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: 703-255-6011

**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 the 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.