CAPITAL AREA INTERNAL MEDICINE

Ph: (703) 255-6010 Fax: (703) 255-6011

2235 Cedar Ln Suite #302
Vienna, VA 22182

www.Capitalima.com

44121 Leesburg Pike #250
Ashburn, VA 20147

PATIENT REGISTRATION FORM

□ **New** □ **Changes/Updates**

(If Changes/Updates – Please indicate only what has changed

PERSONAL INFORMATION

Patient's Last Name: _____ Middle: _____ First: _____

Last 4 of SSN#: _____ DOB: ____/____/____ Age: _____ Sex: ☐F ☐M Marital Status: ☐M ☐S ☐W ☐D

Race: _____ Ethnicity: (Check one) ☐Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline to Specify

Home Address: _____ City: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____ Cell: _____

Local Pharmacy Name: _____ Telephone: _____

Pharmacy Address: _____ City: _____ State: _____ Zip: _____

Prior Primary Care Physician Name and Telephone Nbr: _____

Patient Email: _____ Preferred way of communication: _____

Emergency Contact Name: _____ Relationship: _____ Telephone: _____

Employer: _____ Occupation: _____

Employment Address: _____ City: _____ State: _____ Zip: _____

BILLING AND INSURANCE INFORMATION - We will request to scan your ID and insurance card

1. Primary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ DOB: ____/____/____ SSN#: _____

Relationship to Insured: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER _____

2. Secondary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ DOB: ____/____/____ SSN#: _____

Relationship to Insured: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER _____

3. Tertiary Insurance: PLEASE LET STAFF KNOW IF YOU HAVE ANY TERTIARY ISNURANCE

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HOW DID YOU HEAR ABOUT US?

Whom can we thank for the referral?

☐Physician ☐Insurance ☐Business ☐Family ☐Friend ☐Internet ☐Other Name:_____

WORKMAN'S COMPENSATION AND AUTO ACCIDENT-RELATED INFORMATION

Worker's Comp Name:_____ Auto Insurance Company:_____

Date of Accident: _____ Where:_____

Claim or File No._____ Adjuster/Contact person name:_____

Adjuster/Contact person telephone:_____

ADVANCED MEDICAL DIRECTIVE

Do you have one? ☐ Yes ☐No

If so, please provide our office with a copy for your records. If not, please ask our office for more information.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: Capital Area Internal Medicine Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance within 45 days. Should it become necessary to turn my account over to an outside collection agency I will be responsible for collection costs, attorney fees, litigation fees and court costs. I hereby authorize Capital Area Internal Medicine, Inc. and its employees and agents, to release all information, reports and records if necessary to secure the payment of my account, including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals, and doctors.

_____ _____ _____

Signature **Patient/Policy Holder** **Date**

Responsible Person if Patient is a Minor: _____

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Please review this notice carefully. It describes how health information about you, as our patient, may be used and disclosed.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please review this notice carefully. It describes how your health information may be used or disclosed.

A. Our commitment to your privacy – We are committed to maintaining your privacy. We will create records of your health information and the treatment and services we provide to you. We are required by law to maintain your privacy and to notify you of our legal duties and privacy policies. We reserve the right to revise or amend this Notice of Privacy Practices - the revised or amended notice will apply to all records created in the past or future. We will post a copy of our current notice in a visible location, and you may request a copy of our current notice at any time.

B. We may use and disclose your individually identifiable health information (IIHI) in the following ways:

a) Treatment: We may use and disclose your IIHI to treat you, by having laboratory or radiology tests done to make a diagnosis or to order medication for you. People who work for our practice may use your IIHI to assist in your treatment.

b) Payment: We may use and disclose your IIHI to bill and collect payment for our service to you. We may contact your insurance company to check benefits and pre-certify a treatment. We may use and disclose your IIHI to bill you or family members for your services.

c) Health care operations: We may use and disclose your IIHI to evaluate our quality of care or our business operation.

d) Appointment Reminders: We may use and disclose your IIHI to remind you of appointments.

e) Release of information to family/friends: We may release your IIHI to family or friends who are involved in your care (with your permission).

f) Disclosures Required by Law: We will use and disclose your IIHI when we are required to do so by federal, state, or local law.

C. Use and Disclosure of your IIHI in Special Circumstances

a) Public Health: We may disclose your IIHI to public health authorities for:

i) Vital record- birth and death

ii) Reporting child abuse or domestic abuse (with the victim's permission)

iii) Preventing or controlling disease or injury (including communicable disease)

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b) Health Oversight Activities: These include investigations, inspections, audits, surveys: civil, administrative, and criminal procedures and actions: and other activities needed for compliance with government programs, civil rights law, etc.

c) Lawsuits and Similar Proceedings: We may use and disclose your IIHI as requested by a court administrative or other lawful order. We will try to inform you of the request.

d) Law Enforcement: We may release your IIHI if asked by a law enforcement official
   i) To investigate a crime
   ii) In response to a warrant, summons, court order, subpoena, etc.
e) Serious Threats to Health or Safety: of an individual or the public.
f) Military: We may disclose your IIHI if required by the appropriate authorities.
g) National Security: We may disclose your IIHI to federal officials authorized by law.
h) Workers Compensations: We may release your IIHI for these programs.

I hereby give my consent for Capital Area Internal Medicine to use and disclose my IIHI as outlined above to carry out treatment, payment, and health care operations (HCO).

With this consent, Capital Area Internal Medicine, may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the proactive in carrying out HCO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

We could use secure email/secure SMS/messages to the portal in our communication with you.

With regard to SMS communication please note the following:

- Messaging frequency may vary
- Message and data rates may apply
- To opt out at any time, text STOP
- For assistance, visit our website at https://www.capitalima/com

With this consent, Capital Area Internal Medicine may mail to my home or other alternative location any items that assist the practice in carrying out HCO, such as appointment reminders and patient statements. I have the right to request that Capital Area Internal Medicine restrict how it uses or discloses to carry out HCO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Capital Area Internal Medicine to use and disclose my IIHI to carry out HCO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Capital Area Internal Medicine may decline to provide treatment to me.

Signature of Patient/Guardian: _____ Date: _____

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Office Policy Information

PLEASE NOTE: All charges and/or fees are due at the time of service, when applicable. Please present your insurance card(s) and driver's license to the office staff with this completed form. We will copy them for your records and return them to you immediately.

PATIENT BALANCES
All patient balances, including co-pays, deductibles, co-insurance, and self-pays are due prior to your visit. We reserve the right to cancel your appointment if your balance is not up to date.

INSURANCE CARDS AND IDENTIFICATION
All patients are required to provide their updated insurance card and identification prior to your appointment. It is also your responsibility to bring all insurance cards and identification with you for each visit and present it to the front office to make a copy for your records.

APPOINTMENTS
In scheduling appointments, it is our intent to see you as soon as possible, given the constraints of our mutual schedules. Our staff will offer you the first available appointment and will ask you some basic questions. Our staff will make every effort to accommodate requests. We will make every effort to see you on time at your scheduled visit, however, to avoid delaying other patients; individuals arriving early for their appointments may not be taken until their scheduled time. Please be aware that emergencies do arise which might delay your scheduled appointment. You will receive a call reminding you of your appointment time. Please call us back if you need to change the time of your appointment to avoid any missed appointment charges.

BILLING INQUIRIES
Please call (703) 831-1135 for all billing questions. Our billing office staff will make every attempt to assist you at the time of your call. To facilitate their efforts, please have the necessary information available that you wish to discuss.

COMPLETION OF FORMS
We will be happy to complete the attending physician's statement, insurance, and disability forms for our patients. The patient is responsible for payment of any fee prior to completion of the forms**. Please allow 10-14 business days for completion of forms.**

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PRESCRIPTION REFILLS

All prescription refills must be completed at the time of your appointment. We do not refill medications by phone or automated pharmacy. Your provider will prescribe enough medication until your next follow up appointment. If you are prescribed a medication requiring more frequent office visits you must be up to date with your visits to receive a prescription refill. It will be necessary for you to schedule an office visit for your prescription to be renewed. Patients are instructed to schedule their doctor visits before running out of medicine and have all needed prescriptions before leaving the office at the time of their appointments.

CLINICAL PHONE CALLS

To avoid disrupting the daily patient flow, please choose the appropriate phone option and follow the instructions for a return call from the office staff. Please indicate where you may be reached during the day or whether we have permission to leave a message at the number provided. Messages are retrieved throughout the business day. Urgent requests are handled as soon as possible. All other calls requiring follow up will be returned before the end of the next business day.

FINANCIAL POLICY

We require all of our patients to pay their portion of payment for services rendered including co-pay, co-insurance, deductible and any lab draws done in-house that are not covered by your insurance plan. Payments may be made in the form of cash, check, MasterCard and Visa. Please be aware that current federal regulations require us to collect all co-pays and bill for all services rendered.

TEST RESULTS

Results are generally received in our office within 7-10 days after tests have been performed. Our providers review all reports. Normal results will be posted to your patient portal or via secured email if you do not have a patient portal. For any results that require intervention, you will be contacted to set up a follow-up appointment.

REFERRALS

For those plans requiring referrals to specialty physicians, you must first receive authorization from your provider who is your designated primary care provider (PCP). To request a referral, please call the office at (703) 255-6010. If you have not been seen by your treating provider within the past six (6) months for the condition necessitating the referral, you will need to schedule an office visit prior to receiving the referral. It is the patient's responsibility to inform office if a referral is required before seeing the specialist. It generally takes 2-3 business days to obtain it from the insurance.

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MEDICAL RECORDS

Original records are the property of the Practice and will not be released. Per federal regulations, we require a signed Release of Medical Records form prior to processing of requests. Medical records will not be faxed. Pursuant to Virginia Code subsection B of 8.01-413, there will be charges surrounding duplication of records in the amount of

$0.50 per page for up to 50 pages and $0.25 per page thereafter, plus all postage/shipping costs, and an administrative fee of $10.00. We require payment in advance. Processing will be completed within 15 days from the date we receive your signed authorization and payment. Urgent requests will be treated as such.

DELINQUENT ACCOUNTS

We reserve the right to add reasonable interest and collection charges to any account over 45 days past due. Interest of 1.5% will be added on (for each month) if the balance is not paid in full within 45 days.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Capital Area Internal Medicine for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

YOUR INSURANCE

We will be happy to bill your insurance carrier for you. Please note that we **do not take assignment on auto- related claims** or insurance carriers that we do not participate in. If your insurance requires a referral, it is **required** that **you have your referral with you at the time of service. It is your responsibility to ensure that your referral is current**. Co-payments/co-insurance is due at the time of service. In the event your health plan determines a service to be "not covered" or it has been over sixty (45) days with no payment from your insurance; then you will be responsible for the complete charge. In that event, we will bill you, and **payment is due upon receipt of that statement.**

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

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MINOR PATIENTS
For all services rendered to minor patients, the adult accompanying the patient is responsible for payment

CANCELLATIONS
We require twenty-four (24) hour notice for all cancellations; otherwise, there will be a $30 charge. Work-related cancellations are not excused cancellations, and you will incur a charge.

RETURNED CHECK
It is our office policy to charge a fee of **$35.00 for any returned checks.**

DECLARATION: I have read, and I understand the financial and Office policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by practice.

_____ _____

SIGNATURE & NAME of patient / insured / guarantor / responsible party **DATE**

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MEDICATION REFILL POLICY

Capital Area Internal Medicine participates with electronic prescribing directly to your mail order and local pharmacies. Our goal is to assist patients with prescription requests in an efficient and timely manner. However, due to the volume of prescription requests, we have created the following guidelines to help meet these goals.

Capital Area Internal Medicine is no longer accepting medication refill requests by phone. All medication refill requests now require a follow-up appointment with one of our providers, at which time, your refill request will be submitted.

1. Prescription refills require close monitoring by your provider to ensure their safety and effectiveness. Your provider will prescribe the appropriate number of prescription refills to last until your next scheduled appointment. Generally, when you are down to zero refills, it is time to schedule a follow-up appointment. We prefer that you request any refills of your medications at the beginning of your office visit.

2. It is the patient's responsibility to notify the office to schedule a follow-up appointment in the event you need a medication refill.

3. Patients requesting new prescriptions, or antibiotics must be seen for an appointment. They are not prescribed over the phone because it generally requires an office visit.

4. Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

5. Some medications require prior authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

6. It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no-shows or cancellations will result in a denial of refills.

7. If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please contact us immediately.

I understand that Capital Area Internal Medicine will not take medication refill requests by telephone or by automated pharmacy refill requests. All medication refill requests require a follow-up appointment, at which time your medication refill request will be submitted.

_____ _____

SIGNATURE & NAME of patient / insured / guarantor / responsible party **DATE**

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I)*	**DOB:** _____
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**
Race: _____	
Ethnicity: ☐Hispanic or Latino ☐Non- Hispanic or Latino ☐Declined to Specify ☐Unknown	
Sex: ☐ M ☐ F ☐ U **Gender Identity** _____ **Sexual Orientation** _____	
Gender at Birth _____	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other _____		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed, when and if resolved

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Mild/Moderate/Severe	Type of Reaction

Non-Drug Allergies

Name the Drug	Mild/Moderate/Severe	Type of Reaction

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

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HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise

☐ Sedentary (No exercise)

☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)

☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)

☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet

Are you dieting? ☐ Yes ☐ No

If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No

# of meals you eat in an average day? _____

Rank Salt Intake ☐ High ☐ Med ☐ Low

Rank fat Intake ☐ High ☐ Med ☐ Low

Caffeine

☐ None ☐ Coffee ☐ Tea ☐ Cola

# of cups/cans per day? _____

Alcohol

Do You drink alcohol? ☐ Yes ☐ No

If yes, what kind? _____

How many drinks per week? _____

Are you concerned about the amount you drink? ☐ Yes ☐ No

Have you considered stopping? ☐ Yes ☐ No

Have you ever experienced blackouts? ☐ Yes ☐ No

Are you prone to "binge" drinking? ☐ Yes ☐ No

Do you drive after drinking? ☐ Yes ☐ No

Drugs

Do you currently use recreational or street drugs? ☐ Yes ☐ No

Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Other

Do You Take Birth Control Pills? ☐ Yes ☐ No

Do You Take Stimulants/Pep Pills ☐ Yes ☐ No

Do You Take Laxatives? ☐ Yes ☐ No

Do You Take Tranquilizers? ☐ Yes ☐ No

Do You Take Vitamins? ☐ Yes ☐ No

Do You Take Sedatives/Sleeping Pills? ☐ Yes ☐ No

Smoking Status

☐ Current Smoke ☐ Former Smoker ☐ Never Smoker

If Current or Former Smoker Please answer the following Questions:

Cigarettes – pks/day _____ Chew - #/day _____ Pipe - #/day _____

Cigars Per Day _____ Nbr. of Years _____ or Year Quit _____

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WOMEN ONLY

Age at onset of menstruation: _____		
Date of last menstruation: _____		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam? _____		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam? _____		

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PAST MEDICAL HISTORY

☐ Yellow jaundice ☐ Pancreatitis ☐ Gallbladder trouble ☐ Diabetes ☐ High blood pressure ☐ Stroke ☐ kidney disease ☐ Bladder trouble ☐ Prostate trouble ☐ Scarlet fever ☐ Arthritis, Gout ☐ Bursitis ☐ Epilepsy, seizures ☐ Migraine headaches ☐ Nervous breakdown ☐ Syphilis or gonorrhea	☐ Glaucoma ☐ Tuberculosis ☐ Histoplasmosis, Sarcoidosis ☐ Herpes ☐ Anemia ☐ Diphtheria ☐ Chicken Pox ☐ Measles ☐ German measles ☐ Mumps ☐ Mononucleosis ☐ Polio ☐ Bronchitis ☐ Emphysema ☐ Asthma ☐ Hay fever	☐ Rheumatic fever ☐ Rheumatic heart disease ☐ Angina pectoris ☐ Heart attack ☐ Heart failure ☐ Heart murmur ☐ Hiatus Hernia ☐ Ulcer ☐ Diverticulosis ☐ Diverticulitis ☐ Hemorrhoids ☐ Parasites (worms) ☐ Hernia ☐ Liver disease ☐ Cirrhosis ☐ Hepatitis
Are you allergic to: ☐ Penicillin ☐ Sulfa ☐ Mycins ☐ Morphine ☐ Codeine ☐ Other drugs _____	**When was your Last:** **complete physical** _____ **Eye examr** _____ **Colonoscopy** _____ **Dental appt.** _____ **Tetanus shot** _____ **Pneumonia vaccine** _____	**When was your Last:** **Flu shot** _____ **Chest x-ray** _____ **EKG** _____ **Sigmoidoscopy** _____ **PSA** _____

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FAMILY HEALTH HISTORY

PLEASE NOTE THE ILLNESS OF THOSE LIVING OR DEAD. PLEASE MARK AN "X" IF YES, LEAVE BLANK FOR NO.

HISTORY	FATHER	MOTHER	BROTHERS	SISTERS	SPOUSE	CHILDREN	OTHER
IF LIVING: AGE							
IF DEAD: AGE AT DEATH							
ALCOHOLISM							
ALLERGIES							
ANEMIA							
ARTHRITIS: PLEASE INDICATE WHERE							
ASTHMA							
BLOOD DISEASE							
CANCER: PLEASE INDICATE TYPE OF CANCER							
DEMENTIA							
DIABETES							
EPILEPSY							
GLAUCOMA							
GOUT							
HAY FEVER							
HEART ATTACK							
HIGH BLOOD PRESSURE							
KIDNEY DISEASE							
LIVER DISEASE							
MIGRAINE HEADACHES							
NERVOUS BREAKDOWN							
STROKE							
THYROID DISEASE: PLEASE INDICATE TYPE							
TUBERCULOSIS							
ULCER							
OTHER							
OTHER							
OTHER							

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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: Capital Area Internal Medicine

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 it 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.