The Center for Ear, Nose & Throat
5801 Allentown Road, Suite 209
Camp Springs, Md. 20746

Capital Orthopedics Specialists LLC
7404 Executive Place, Suite 350
Lanham, Md. 20706
Attn: Michael Walker/Michael Maloney

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name:_____

Address_____

City_____ State_____ Zip_____

Patient's DOB:_____ SS #_____ Phone#_____

I authorize Center for Ear, Nose & Throat to take the following action:
[ ] Send my medical records to: OR [ ] Obtain my medical records from:

Name_____
(Please print name and full address)

Address_____

_____
City State Zip

Phone#_____ Fax# _____

[ ] Include all medical records. **DO** release HIV/AIDS and/or sexually transmitted disease-related and/or psychological or psychiatric treatment and/or drug/alcohol abuse or treatment information, if applicable. I understand that this a dual release inclusive of sensitive medical information, including HIV.

[ ] Include all medical records, with the exception of the following selected items:_____
_____

[ ] Send/obtain only the following selected items:_____
_____

I understand that my consent to release/obtain information will expire in one (1) year. I understand that I may withdraw this consent in writing at any time.

Signed:_____ Date_____

Witness_____ Title_____ Date_____