CAPITAL MEDICAL CLINIC, LLP

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Authorization to Release Private Health Information (PHI)

I hereby authorize Capital Medical Clinic to release my PHI (private health information) to the following people. This authorization will remain in effect until I complete a new Authorization to Release PHI form.

Patient Name_____DOB_____DATE_____

Name _____
relationship

Name _____
relationship

Name _____
relationship

Name _____
relationship

Name _____
relationship

Privacy Protection:

OK to call you at work?	Y	N	N/A
OK to speak to your spouse about medical and billing information?	Y	N	N/A
OK to leave medical and billing information on your home voice mail?	Y	N	N/A
OK to leave medical and billing information on your cell phone voice mail?	Y	N	N/A
Do you have a POA (Power of Attorney) ?	Y	N	N/A

If Yes please list POA contact information:

Name (First/Last):_____

Address: _____
(City) (State) (Zip Code)

_____
Patient signature, signature of parent/guardian of minor patient or POA (Date)

_____
Please print your name (please use your legal name or the name on your insurance card) Relationship to patient