

Capital Healthcare Associates
A member of East Hudson Community Care Physicians
2001 Fifth Ave, Troy, NY 12180
Telephone: (518) 274-9126 Fax: (518) 274-9487

Authorization For Release Of Medical Information

(Please complete the following with information pertaining to your previous Primary Care Physician)

Provider: _____

Address: _____

You are authorized to furnish and release to the Provider indicated below, all information and records requested. Any information and records regarding my condition is confidential and may not be disclosed without written authorization by me. This authorization remains in effect until revoked by me in writing.

Patient Name: _____

Date of Birth: _____

Please forward the following:
Last 6 months office notes and labs
Immunization records
Medication List
Problem List

To the attention of the provider listed below:

- | | |
|--|--|
| <input type="checkbox"/> Arsenio Agopovich, MD | <input type="checkbox"/> Michael Wolff, MD |
| <input type="checkbox"/> James M. Cioffi, MD | <input type="checkbox"/> Prabhakar R Chava, MD |
| <input type="checkbox"/> James D. Walders, MD | <input type="checkbox"/> Donald Jue, MD |
| <input type="checkbox"/> Ronald V. Musto, MD | <input type="checkbox"/> Patricia Saunders, MD |

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of information. This authorization will expire on: _____
(Expiration Date)

Signed: _____ Date: _____

Relation to Patient: _____