CAPSTONE MEDICAL ASSOCIATES
4807 JONESTOWN ROAD, SUITE 141
HARRISBURG, PA 17109

~ MEDICAL RECORDS RELEASE AUTHORIZATION

I HEREBY AUTHORIZE THE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

FROM:

_____
_____
_____
_____

TO:

DR. JEFFREY BACKENSTOES
4807 JONESTOWN ROAD, SUITE 141
HARRISBURG, PA 17109
(717) 695-6177

PATIENT: _____
(NAME) (DOB) (SS#)

ALL _____ (Note: for alcohol/drug, mental/psychiatric, and HIV/AIDS treatment records see specific authorizations below.)

Laboratory work _____ Medication Lists _____
Specified reports _____ Radiology Notes _____
Flow Sheets _____ Progress Notes _____
Other _____

Authorization Signature _____ Date _____ Witness _____

I authorize release of records regarding treatment for ALCOHOL AND/OR DRUG USE.

Authorization Signature _____ Date _____ Witness _____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ I authorize release of records regarding treatment for PSYCHIATRIC/PSYCOTHERAPY/ AND/OR ANY OTHER MENTAL HEALTH RELATED ISSUES.

Authorization Signature _____ Date _____ Witness _____

This information has been disclosed to you from records whose confidentiality is protected by State statute. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains.

I authorize release of records regarding ALL HIV/AIDS RELATED INFORMATION.

Authorization Signature _____ Date _____ Witness _____

This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Consent Expiration Date _____

Consent may be revoked in writing at any time except to the extent that the person/organization making the disclosure has already acted in release on it.