CAPE MEDICAL GROUP

Outside Record Release or Disclosure of Health Information

Patient Name: _____ DOB: _____

Address: _____

Dear: _____ Fax Number: _____

I am requesting that you release my medical records to:

Cape ENT
17005 Old Orchard Rd
Lewes, DE 19958

Phone: (302)703-4025 Fax: (302)703-4027

Please release only the following:

- ☐ Entire Chart
- ☐ Last Office Note
- ☐ Other: _____

I understand that I do not have to sign this authorization in order to obtain healthcare benefits and I may revoke this authorization in writing at any time except to the extent action has been taken in reliance on this authorization. I understand that the information may be subject to redisclosure by the recipient listed above, at which time it may no longer be protected under federal HIPAA Privacy Rules.

_____

Signature of Patient, Guardian or Medical Power of Attorney *Date*

THIS AUTHORIZATION WILL EXPIRE IN 90 DAYS