George Conrad, M.D., FACS
Gian-Paul Vidal, M.D.

Medical Records Release

_____ Print Patient's Full Name

_____ Date of Birth (Mo/Day/Year)

_____ Street Address

_____ Social Security Number

_____ City, State, Zip Code

_____ Home Phone

_____, do hereby authorize _____ to release the following:
Patient's Name Your PCP, referring provider or other doctor

_____ Medical History ____ Radiology Reports _____ Immunization Records

_____ Progress Notes ____ EKG Results _____ Other Ancillary Reports

_____ Laboratory Reports _____ Other: _____

___ I do ___ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

PURPOSE OF DISCLOSURE:

___ Referral to Specialist ___ Continuation of care _____Change of Doctor ___ Other:_____

INFORMATION RELEASED TO:

Capitol Surgeons, LLC
8630 Fenton Street, Suite 122
Silver Spring, MD 20910
Phone: 301.588.0057 Fax: 301.588.0014
___ George Conrad, M.D., FACS ___ Gian-Paul Vidal

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 90 DAYS from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether I sign the authorization.

_____ Patient Signature
(Guardian or Personal Representative of Patient's Estate)

_____ Date