Nikolas G. Capetanakis, D.O.

317 N. El Camino Real, Suite 101, Encinitas CA 92024
Phone: 760.634.2814 Fax: 760.634.6785
www.DrCap.net

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: ____ Date of Birth: ______________________________
Address: ____
City: _____________________________ Zip Code: ________________ Phone: _______________________________

I request and/or authorize: ____
Address: ____
City: ______________________________ Zip Code: ____
Phone: ______________________________ Fax: ____

To release the following medical records: ____
____
From Date: ______ / ______ / ________ To Date: ______ / ______ / _________

To be released to: Nikolas G. Capetanakis, D.O.
317 N. El Camino Real, Suite 101
Encinitas, CA 92024
Phone: 760.634.2814 Fax: 760.634.6785

Reason for request:
__ Notification to my primary care physician
__ Transferring Medical Care
__ Moving out of area
__ Other: ____________________________

____
Patient/Guardian Signature

____
Date of Request

Only the information you have requested will be released or received. You have the right to revoke this authorization at any time by submitting a written notice to the receptionist at the front desk. There may be a fee for copying and mailing/faxing medical records.

For Office Use Only:
Request to be given to: __ Provider ____________________________
__ Billing ______________________________
__ Auth/Ref ____________________________