Nikolas G. Capetanakis, D.O.

535 Encinitas Blvd, Suite 120, 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.
535 Encinitas Blvd, Suite 120
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 _____