Office initials

Capital Healthcare Associates
101 Jordan Road Suite 100 – Troy, NY 12180
Phone: (518) 274-9126 Fax: (518) 274-4835

Authorization For Release of Medical Records to CHA

Patient Name: ______________________________

Date of Birth: ______________________

Provider: ______________________________

Phone: ______________ Fax: ______________

You are authorized to furnish and release to the provider indicated below, all information and records requested. Any information and records regarding my condition is confidential and may not be disclosed without written authorization by me. This authorization remains in effect until revoked by me in writing.

Reason for release: [ ] Change of Primary Care Physician [ ] Did not receive listed report

[ ] Other: ______________________________

Please forward the following:

[ ] Medical Records pertaining to: ______________________________

[ ] Most recent: office note / laboratory report

[ ] Last 6 months of patient records

[ ] Discharge Summary: Facility: ______________ date: ______________

[ ] Laboratory Reports: ______________________________

[ ] Immunizations Records

Please forward records to the attention of the provider below:

[ ] Prabhakar R. Chava, MD
[ ] Ronald V. Musto, MD
[ ] James D. Walders, MD
[ ] Michal Wolff, MD
[ ] Edward Foley, DO
[ ] Janice Dort, PA-C
[ ] Julia Roske, PA-C
[ ] Lisa Eberhardt, NP
[ ] Patricia Hobbs, NP

Signed: ______________________________ Date: ______________

Relation to Patient: ______________________ Exp date: ______________