CAPITAL DIGESTIVE CARE℠
First in Digestive Health

Maryland Digestive Disease Center

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Records Release

To: _____
(Physician or party you wish to get records from)

I hereby authorize you to release the following medical records including the diagnosis and records for any treatment or examination rendered to me by the above referenced physician_____
(Specific records you wish to be released)
_____
_____
_____
_____
_____

to _____.
(Physician or party to whom you wish records to be released to)

_____ _____
(Patient's printed name and date of birth) ***(Patient's Signature)***

_____ _____
(Witness) ***(Patient's Address)***

7350 Van Dusen Road
Suite 210 or 250
Laurel, MD 20707
301-498-5500
Fax: 301-498-7346

5500 Knoll North Drive
Suite 460
Columbia, MD 21045
410-730-9363
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7610 Carroll Avenue
Suite 250
Takoma Park, MD 20912
301-270-3640
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(02-17-15 gg)