Metropolitan Med Trauma Group
Douglas C. Frankel, M.D., P.A.

♦ EMERGENCY/TRAUMA MEDICINE ♦ INTERNAL MEDICINE ♦
♦ SPORTS MEDICINE ♦ CORPORATE MEDICINE ♦

♦ **PHYSICAL THERAPY** ♦

1680 E. Gude Drive 301-217-9222 Main Office
Rockville, Maryland 20850 301-217-9224 Fax

Patient Registration Form

Fax To: ______________________________ Date: _____________

Attention: ____________________________ Time: _____________

Company: ____________________________ Pages: _____________

Comments: ____

Authorization for Medical Records Release:

To Whom It May Concern:
Please release and provide to Douglas C. Frankel, M.D., P.A. copies of any and all medical records, summaries, lab results, x-rays, CT scans, MRI scans and reports taken for the patient listed below. These records are requested in order to provide further medical care.

Authorization for Medical Treatment:

I, the undersigned patient in this office hereby authorize Dr. Douglas Frankel and his associates to perform such treatment and perform diagnostic procedures as are considered therapeutically necessary based on the findings during the course of said treatment. I reserve the right to have all of my questions answered prior to performing testing/treatment. I hereby certify that I have read and fully understand the authorization for medical treatment and the reason why certain diagnostic procedures are necessary, their advantages and possible alternative modes of treatment, as explained by Dr. Frankel and/or associates. I certify that no guarantee or assurance has been made to me as to the results that may be obtained.

____ ________________________
Patient's Name Date of injury/visit

____ ________________________
Patient's Signature or Guardian's Signature Today's Date

____ ________________________
Social Security # Date of Birth Witness