



Comprehensive Neurology and Sleep Medicine, P.A.

Konrad Bakker, MD
Board Certified in Neurology
and Sleep Medicine

Navid Mostofi, MD
Neurologist
Neurophysiologist

Sarah Layman, PA-C
NCCPA Certified
Physician Assistant

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED
HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Comprehensive Neurology and Sleep Medicine to use and/or disclose certain protected
health information (PHI) about me:

Patient Name _____ Date of Birth _____

to or for the party or parties listed below. I understand that PHI may contain medical information pertaining to treatment for
psychiatric, drug and/or alcohol abuse and HIV/AIDS diagnoses and treatment.

This authorization permits Comprehensive Neurology and Sleep Medicine to use or disclose PHI to the following party or parties:

Name: _____

Address: _____ City/State/Zip: _____

Specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.

I ___ do ___ do not want information relating to psychiatric, drug and/or alcohol abuse and HIV/AIDS diagnoses and
treatment included in this release.

- Complete Chart (all documents/notes relating to my care)
Lab/Test Results
Medications/Dosages
Progress Notes
H&P Exam
Consultation Reports
Dates to/from: _____

Other: _____

The information will be used or disclosed for the following purpose: _____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This
authorization will expire on _____ (Date of defined event, if no date listed this authorization will expire in six (6) months.)

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may
no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent
that Comprehensive Neurology and Sleep Medicine has acted in reliance upon this authorization. My written revocation must be
submitted to Office Manager, CNSM, 172 Thomas Johnson Drive, Suite 100, Frederick, Maryland 21702.

Signature of Patient/Legal Guardian _____ Date _____

Print Name of Patient/Legal Guardian _____ Date _____