Comprehensive Neurology and Sleep Medicine, P.A.

**Konrad Bakker, MD**
Board Certified in Neurology
and Sleep Medicine

**Sarah Jamieson, 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 Dates to/from: _____________________
_____ Medications/Dosages Dates to/from: _____________________
_____ Progress Notes Dates to/from: _____________________
_____ 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


172 Thomas Johnson Drive, Suite 100, Frederick, MD 21702 301-694-0900
1901 Research Boulevard, Suite 160, Rockville, MD 20850 301-294-5509
Fax 301-694-0657 www.MyNeurologyPractice.com