David W. Kossoff, MD, PA
GASTROENTEROLOGY

Authorization to Release Medical Information
By: David W. Kossoff, M.D.

1. I AUTHORIZE:
David W. Kossoff, M.D.
56 Thomas Johnson Drive
Suite 110
Frederick, Maryland 21702
Phone: 301-624-5566 Fax: 301-624-5542

2. RELEASE TO:
_____
Name of sending person/ organization

_____
Street Address

_____
City State Zip Code

3. **INFORMATION TO BE RELEASED: (CHECK ALL APPLICABLE)**
☐ All Information ☐ All Progress Notes ☐ All Lab Reports ☐ All X-Ray Reports
☐ All Procedure Reports ☐ All Pathology Reports ☐ Other_____

SPECIAL AUTHORIZATION: CHECK APPLICABLE BOX(ES) AND SIGN IMMEDIATELY BELOW.
BY SIGNING BELOW, I AM AUTHORIZING THE OFFICE TO RELEASE ANY AND ALL INFORMATION REGARDING:

☐ ALCOHOL ☐ DRUGS ☐ MENTAL HEALTH ☐ SEXUALLY TRANSMITTED DISEASES ☐ HIV ☐ AIDS

NOTE: If this release pertains to alcohol, drugs, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rule prohibits you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: _____ Date: _____

4. **RECORDS FROM THE TIME PERIOD (Please check one of the two options below)**

☐ For the following time period: _____ through _____
☐ No time period specified

5. **PURPOSE OF DISCLOSURE: (check applicable purpose)**
☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal
☐ Personal ☐ Worker's Compensation Claim ☐ Other: _____

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. The requestor may be provided with a copy of this authorization form, if it is requested.

PRINT NAME: _____

PATIENT SIGNATURE_____

DATE OF BIRTH: _____ HOME #: _____ WORK #_____

FOR OFFICE USE ONLY:
Acct: # _____ Date: _____ Initials of staff member sending_____