



# Optimal Digestive Care

David W. Kossoff, MD

Lindsay Bitto, CRNP • Erin Oman, CRNP

70 Thomas Johnson Drive Suite 120 Frederick, MD 21702

Phone (301) 624-5566 • Fax (301) 624-5542

www.OptimalDigestiveCare.com

**1. I AUTHORIZE:**

\_\_\_\_\_  
Name of sending person/ organization

\_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip Code

**2. RELEASE TO:**

Optimal Digestive Care

**PLEASE FAX RECORDS TO: (301)624-5542**

**3. INFORMATION TO BE RELEASED: (CHECK ALL APPLICABLE)**

All Radiology Reports

All Procedure Reports

**ENTIRE MEDICAL RECORD**

All Pathology Reports

All Lab Results

All Office Notes

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

MENTAL HEALTH

HIV

DRUGS

SEXUALLY TRANSMITTED DISEASES

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:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_