NORTHERN
ANESTHESIA &
PAIN MEDICINE, LLC

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO NAPM

Patient Name: _____ Date of Birth: _____ Phone:_____

I authorize the following healthcare provider to disclose the following health information of mine to Northern Anesthesia & Pain Medicine, LLC (NAPM) (o) 907-622-7246 (f) 907-622-7247

Healthcare Provider disclosing health information:

Name: _____ Phone: _____ Fax: _____

Health information to be disclosed: (check appropriate box)

☐ All records within 2 year period prior to last date seen by the healthcare provider
☐ The following health information (be specific): _____
_____

** I understand that the health information authorized to be disclosed under this Authorization may include information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.*

The health information is being disclosed for the following purpose: (check appropriate box):

☐ Change of Insurance or Physician
☐ Continuation of Care
☐ At the undersigned Patient's request
☐ The following purpose (be specific): _____

I understand I may revoke this Authorization at any time by sending written notice of my revocation to NAPM's health information management department. I understand that my revocation will not be effective to the extent the healthcare provider has taken action in reliance on this Authorization.

Unless revoked sooner, this Authorization will expire on the following date, event, or condition: _____. If no date, event, or condition is written, this Authorization will expire 1 year from the date signed. A photocopy of this Authorization will be considered effective and valid as the original.

I understand that NAPM may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may redisclose the records and that the records may no longer be protected by Federal privacy regulations.

Please Note: Fees May Be Charged For Copying Medical Records

I have read this Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative (Guardian or Authorized Representative must attach documentation of such status.) — Date

_____ _____

Printed name of Authorized Representative and Telephone Number — Relationship / Capacity to Patient