**Authorization to Disclose Health Information**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I authorize NAPM to disclose my health information to the following recipient.*

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I authorize the following healthcare provider to disclose my health information to Northern Anesthesia & Pain Medicine, LLC.*

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***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.***

***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 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 disclose 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.***

Information to be disclosed: (Circle all that apply)

Complete Medical Records. Specific Health Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Disclosure: (Circle all that apply)

Change of Insurance or Physician. Continuity of Care. Patient Request. Other:\_\_\_\_\_\_\_\_\_\_

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

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_