NORTHERN
Anesthesia & Pain Medicine, LLC

CONSENT TO RELEASE/RECEIVE PROTECTED HEALTH INFORMATION (MEDICAL RECORDS)

I, _____ DOB_____ request/authorize Northern Anesthesia & Pain Medicine (NAPM) and (name of organization/ individual / third-party payer)_____
Mailing Address:_____
Phone Number:_____Fax:_____Email:_____

To communicate and disclose to one another the following information:
Specific information to be released: (initial all that apply)

____all listed below **Or:**

____Initial consult note:
____Follow-up notes:
____Urinalysis/drug testing results
____Other in office test results (ECG, pregnancy, glucose)
____Procedure notes
____Acupuncture notes
____Financial/Payment Information

For the purpose of: (initial all that apply)

____all listed below **Or:**

____Further treatment/coordination of care
____payment and healthcare operations
____legal purposes
____financial
____other_____

Term: I understand that this Authorization will remain in effect:
□ Until one year from my last date of service with NAPM, OR
□ From the date of this Authorization until the _____day of _____, 20 _____.

Refusal to sign/Right to revoke I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement or continuation of my treatment at NAPM (however my NAPM Providers may not be able to provide me with the best care possible if they are lacking information about me.) If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to NAPM. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation. To revoke this Release of Information, sign, and date the section on the back of this form.

I understand that the records to be released may contain information pertaining to psychiatric/psychological treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand my alcohol/drug treatment records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient. I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

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TO REVOKE RELEASE OF INFORMATION, COMPLETE THE FOLLOWING SECTION:

I, _____ Do NOT authorize Northern Anesthesia & Pain Medicine (NAPM) to receive or release my protected health information (PHI) /medical records from/to the entities named in this document. I choose to revoke this Authorization. This change will be effective immediately upon receipt of my written notice to my health care provider. I understand this revocation will not effect actions taken by my health care provider in reliance on this Release of Information Authorization prior to receipt of my written notice.

_____

Patient Signature Date

_____

Witness Signature Date

_____

Printed name of Patient Printed name of Witness

Notice to recipients of released information: If the information released pertains to drug and alcohol abuse, the confidentiality of the information is protected by federal law (CFR 42, Part 2) prohibiting you from making any further disclosures of this information without specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42, part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.