NEUROVERSION
Break the cycle of pain

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of birth: _____

Address (1): _____

Address (2): _____

Phone number: _____

I authorize: _____

Address (1): _____

Address (2): _____

Phone number: _____ Fax number: _____

To release records to: Neuroversion

Address (1): 2925 Debarr Road, Suite 240

Address (2): Anchorage, AK 99508

Phone number: (907) 339-4650 Fax number: (907) 339-4694

Information requested:

- ☐ **Complete chart** Specifically: _____
- ☐ **Consult/progress notes in the last:**
  - ☐ One month ☐ Three months ☐ Six months
  - ☐ Other: _____
- ☐ Laboratory/Pathology reports
- ☐ Radiology reports
- ☐ Consultations
- ☐ Hospital records
- ☐ Procedure/Injection notes

For the purpose of:

- ☐ Further treatment
- ☐ Insurance claims/Payment
- ☐ Second opinion
- ☐ Personal records
- ☐ Legal request

To be:

- ☐ Mailed ☐ Faxed
- ☐ Picked up ☐ Portal access

_____ I understand that this information may include history of acquired immunodeficiency syndrome (AIDS); sexually transmitted disease; human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar condition. This does not indicate that I have these conditions but allows the release of the records without review.

_____ I have been provided a copy of **Neuroversion**'s Notice of Privacy Practices and any changes that may be associated with this authorization. I have discussed any concerns I may have about the use, release, and disclosure of my health information disclosed under this authorization. I release **Neuroversion** from any legal liability that may arise from this authorization.

_____ The patient or their representative may revoke this authorization by notifying, in writing, **Neuroversion**'s designated Privacy Officer. Federal Law states that treatment, payment, enrollment, or eligibility benefits may not be condition(s) on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is potential for the protected health information release under this authorization may be subject pre-disclosure by the recipient

Patient Signature: _____ Date: _____

This document expires one year from date signed. A copy of this signed form will be provided to patient or legal representative as well as the specified recipient. The original will reside in patient chart.