NEUROVERSION
Break the cycle of pain

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____

Home Number: _____ Cell Number: _____

I authorize (Clinic or Physician): Neuroversion

Address: 2925 Debarr Road, Suite 240, Anchorage, Alaska 99508

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

To release records to (Clinic or Physician): _____

Address: _____

Phone Number: _____ Fax Number: _____

Information requested:	For the purpose of:	To be:
_____ Complete chart	_____ Further treatment	_____ Mailed
_____ Chart notes	_____ Insurance claimes/payment	_____ Faxed
_____ Laboratory/Pathology reports	_____ Second opinion	_____ Picked up
_____ Radiology reports	_____ Legal request	
_____ Consultation(s)	_____ Personal records	
_____ Hospital records		
_____ Procedure/Injection notes		

Please read and initial each item:

_____ I understand that this information may include any 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 for benefits may not be condition 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 ore-disclosure by the recipient.

Signature of Patient/Representative: _____ Date: _____

Relationship to Patient: _____

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.