

**NORTH AMERICAN PARTNERS IN ANESTHESIA (NAPA)
AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

By signing this form, I hereby authorize NAPA to obtain, use and disclose certain protected health information from the records of:

Patient Name: _____

MRN# (Account number listed on the statement): _____

Date of Birth: _____

Address: _____

Phone Number: _____

Email: _____

The following information may be used and disclosed (including discussion via phone), check all that apply:

- Medical History
- Test Results
- Medications/Prescriptions
- Treatment Plans
- Billing/Insurance Information
- Entire records in NAPA's possession
- Other _____

The persons or class of persons who are authorized to receive this information are (either name specific individuals or the type of persons). Examples may include other healthcare providers, family members or caregivers. If you need additional space, please include an additional page.

Healthcare Provider/Family Member/Representative to Receive Information:

Full Name: _____

Relationship to Patient: _____

Phone Number: _____

Email (if applicable): _____

The purpose for which the records will be used or disclosed is as follows (check one):

- At the request of the individual
- Insurance/Payment
- Other (specify): _____

I understand that I may revoke this authorization in writing at any time, except that such revocation will not affect actions already taken in reliance on this authorization and, if applicable, may not be effective as to an insurer's right to contest a claim. I understand that, in order to revoke this authorization, I must send a written notice stating my intent to revoke this authorization to:

NAPA
Attn: Compliance Officer
1300 Concord Terrace, Suite 420
Sunrise, FL 33323

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Unless revoked earlier, this authorization will expire (choose only 1):

On the following date: _____

Upon the following event: _____

If no expiration date or event is given, it is assumed that this authorization will expire one year after it is signed. I understand that NAPA is not conditioning treatment, payment, or healthcare operations upon my agreement to sign this Authorization.

I understand that the information to be used and disclosed pursuant to this authorization form may include sensitive information such as information relating to (1) human immunodeficiency virus (“HIV”) infection or acquired immunodeficiency syndrome (“AIDS”), (2) treatment for or history of drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care. I understand that to the extent any recipient of this information, as identified above, is not a “covered entity” under federal privacy law, the information may no longer be protected by federal privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

Patient Signature: _____

Date: _____

If this authorization is signed by a Legal Representative:

Printed name of Legal Representative: _____

Representative’s authority to act for the Individual: _____

If signed by a Representative of the individual, we must verify that you are this Individual’s representative. Please enclose any documents that support this authority (Power of Attorney, Court Order, etc.). As this person’s representative, can you be contacted at the address, e-mail or phone number listed above? If not, please provide your address, email and phone number: _____

If the Patient is a Minor or Unable to Sign:

Name of Legal Guardian or Representative: _____

Relationship to Patient: _____

Signature of Legal Guardian or Representative: _____

Date: _____

Return this completed authorization to:

Healthcare Provider Use Only:

First/Last Name of NAPA Representative: _____

Date: _____

Form questions: compliance@napaanesthesia.com

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