Anchorage **Neurosurgical**
ASSOCIATES INC.
BRAIN | SPINE | NERVES | EST. 1981

Health Care Permissions Information

Patient Name: ____

Primary Medical Health Care Provider (First and Lase Name): ______________________

Would you like a copy of your chart notes from today to be sent to them for their records? Yes ☐ No ☐

Other Health Care Providers: Would you like them to receive your chart notes? Yes ☐ No ☐

____ Yes ☐ No ☐

____ Yes ☐ No ☐

Do you have any forms with you today that will need to be completed? Yes ☐ No ☐

Do you have a Nurse Case Manager to assist with your care? Yes ☐ No ☐

<u>Person(s) to Contact in Case of an Emergency</u>

Name: ______________________ Relationship: ______________________

Phone 1: ______________________ Phone 2: ______________________

ANAI may discuss my Medical Info with this person | ANAI may discuss my Billing Info with this person | This person may pick up my prescriptions from ANAI | This person may pick up my records, forms or information

Name: ______________________ Relationship: ______________________

Phone 1: ______________________ Phone 2: ______________________

ANAI may discuss my Medical Info with this person | ANAI may discuss my Billing Info with this person | This person may pick up my prescriptions from ANAI | This person may pick up my records, forms or information

Name: ______________________ Relationship: ______________________

Phone 1: ______________________ Phone 2: ______________________

ANAI may discuss my Medical Info with this person | ANAI may discuss my Billing Info with this person | This person may pick up my prescriptions from ANAI | This person may pick up my records, forms or information

I acknowledge that Anchorage Neurosurgical Associates, Inc may provide my medical information as noted to the person(s) I have designated above.

____ ______________

Signature of Patient, Parent, Guardian, Personal or Legal Representative Date