Anchorage Neurosurgical Associates, Inc.

Aka: **ANAI**

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)

____ ____________

____ ____________

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** _________

Person(s) to Contact in Case of an Emergency

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**