



SPECIALTY PAIN MANAGEMENT CENTER

AJAY M. NARWANI M.D., PLLC

DIPLOMATE IN ANESTHESIA, AMERICAN BOARD OF ANESTHESIOLOGY
DIPLOMATE IN PAIN MEDICINE, AMERICAN BOARD OF ANESTHESIOLOGY

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize:

Dr. Name or Facility: _____

Address: _____

Phone: _____ Fax: _____

To release healthcare information of the patient named above to:

Name: Ajay Narwani

Address: 3008 N. Dobson Rd. Suite 2

City: Chandler State: AZ Zip Code: 85224

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

DEFINITION: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED.