Longship Nursing and Consulting LLC
PO Box 672154, Chugiak, AK 99567 ⁘ 907-854-6877

Notice of Privacy Rights

This HHS.gov notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review and read carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

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Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Minors Privacy Rights: Alaska statutes (AS 25.20.025) permit a minor to obtain certain health care services without the consent of a parent or guardian. When the minor can consent to the services their health information cannot be released to anyone without the consent of the minor.

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PATIENT RIGHTS AND RESPONSIBILITIES

Longship Nursing and Consulting LLC (hereinafter "Longship") understands the ethical and legal obligation it has to a patient regarding their rights when receiving medical care or treatment. These rights are designed to help ensure a patient receives appropriate and ethical healthcare while respecting their autonomy, dignity, and well-being. Alternatively, Longship requests patients recognize their unique role and responsibilities.

Informed Consent: Patients have the right to receive relevant and understandable information about their medical condition, proposed treatments, potential risks and benefits, and alternative options. Patients can then make informed decisions about their care after understanding the information provided. A patient has the right to ask questions at any point, change a decision, and seek second opinions.

Privacy and Confidentiality: Patients have the right to expect that their personal medical information will be kept confidential. Longship works hard to maintain the privacy of patient records and will only disclose information from the patients record either with consent or as required by law. To protect the confidential relationship, Longship representatives will not identify that a relationship exists while in public unless the patient initiates an interaction. Longship provides a separate Notice of Privacy Practices form.

Access to medical records: In general patients have the right to access medical records and obtain copies of their health information. Records are available to the patient or other medical/healthcare entities after a medical release of information (ROI) form that is compliant with Health Insurance Portability and Accountability Act (HIPAA) regulations has been signed by the patient. Records requested by the patient's other healthcare providers will be sent electronically free of charge. Printed or electronically copied (CD/DVD/USB) records requested by the patient will cost $5.00 per copy. Each entity requesting a medical record copy will require a separate ROI.

Nondiscrimination: Patients will be treated with fairness, respect, and without discrimination based on age, color, disability, genetic information, marital status, national origin, pregnancy, race, religion, gender, gender identity or expression, sex, sexual orientation, veteran status, or any other protected characteristic. Longship requests patients treat other patients and Longship representatives with similar respect.

Right to refuse or withdraw treatment: Patients have the right to refuse or discontinue treatment, even if it goes against medical advice, to the extent permitted by law. Patients have a right to make decisions about their own bodies and have the autonomy to accept or decline treatment. There are exceptions in certain circumstances, outlined by laws, such as when it may pose a risk to self or others.

Right to quality care: Patients have the right to receive high-quality, competent, and appropriate medical care that meets the standards of the healthcare profession. This includes being treated by qualified healthcare professionals in a safe and clean environment. Patients have the right to appropriately voice concerns about the service and care received.

Right to access to pain management: Longship understands patients have the right to have their pain assessed and manage appropriately. Longship does not manage chronic pain or chronic pain medications such as narcotics. Longship will assist patients in accessing specialties that manage chronic pain.

Advanced Directives: Patients have the right to choose an Advance Directive to designate the kind of care one wishes to receive should the patient be unable to express wishes. Longship does not prepare or draft Advanced

Directives, but recommends copies be kept on file with Longship records.

Invoice Rights/Good Faith Estimate: Patients have a right to receive an itemized statement and detailed explanation of the bill, aka Superbill. Longship will provide a detailed invoice within 30 days of appointment completion. Upon request, Longship can provide a good faith estimate prior to an appointment. A good faith estimate is based on details provided by the patient before the appointment and before a clinical examination is done. Please be aware other costs may be incurred based on additional needs found during an exam, Longship seeks to keep patients informed of any additional costs or changes.

Minors Rights: A parent or legal guardian must provide consent on behalf of a minor (under age 18) before health care services are provided, with several important exceptions. These exceptions are based on status (i.e. legal independence from parents/guardians) or type of service (certain sexual health and reproductive health issues, emergency services, and certain instances when a parent or guardian cannot be reached). A minor's right to privacy and confidentiality may be legally overridden in certain circumstances. These situations include suspicion of abuse or neglect, including physical injury or neglect, mental injury, sexual abuse, sexual exploitation, maltreatment.

Patient Demands: A right to make decisions about health care does not mean that a patient can demand treatment and/or services that are medically inappropriate, unsafe, unlawful, or unnecessary.

Patient Responsibilities: Patients are responsible for asking questions and making sure the instructions given are understood. Patients are responsible for following the suggestions and advice prescribed in a course of treatment by Longship (this does not supersede a patient's right to refuse treatment or withdraw treatment). Patients are responsible for keeping appointments and arriving on time. Patients are responsible for notifying Longship of demographic updates or changes in insurance status. Patients are responsible for being open and honest with Longship about health history, health changes, substance use, medications or changes, and over-the-counter vitamins/supplements or changes.

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Date ___/___/_____

Last Name: _____ First Name: _____ MI: ___

Gender: _____ SSN: _____-_____-_____ Birthdate: ____/____/_____

Home Phone: _____ Cell Phone: _____ Preferred Contact (circle one): Home or Cell

Street Address: _____

City: _____ State: _____ Zip:_____

Mailing Address: _____

City: _____ State: _____ Zip:_____

Circle One: Married Single Partnered Widowed Name of significant other: _____

Occupation/Employer: _____ Business Phone: _____

Emergency Contact: _____ Relation: _____Contact Phone: _____

Responsible Party (**need only if patient is a minor**): _____

Responsible Party SSN: _____-_____-_____ Contact Phone: _____

Responsible Party Occupation/Employer: _____

Patient Preferred Pharmacy: _____

Do you have medical Insurance? Circle One: No Yes

Longship does not bill commercial insurance, Tricare, or Medicaid. This information is used for referrals, prescriptions, and ordering labs/imaging:

Name of Primary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birthdate: ____/____/____

Insurance Address _____

Name of Secondary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birthdate: ____/____/____

Insurance Address _____

Longship Nursing and Consulting LLC

Name: _____ Date of Birth: _____

Insurance and Billing Notice

Longship Nursing and Consulting LLC (hereinafter "Longship") is in network with several major commercial insurance companies, Tricare, VA, Medicaid, and Medicare. Longship encourages patients to verify coverage prior to appointments, recommended labs, imaging, or referrals. The patient is responsible for confirming their own benefits, coverage, and potential out-of-pocket costs. As part of a patient partnership, Longship will provide medically necessary diagnosis codes, receipts, or other documentation to assist with insurance coverage or reimbursement. Longship does not research or interpret individual insurance policies. Longship will not become involved in disputes between the patient and insurance company regarding deductibles, co-pays, covered charges, secondary insurance, "usual and customary" charges, etc. _____ (initials).

Longship has contracted with Guardian Health Solutions for insurance billing services. In signing this notice, the patient has given consent for Longship/Guardian to use and disclose protected health information (PHI) to carry out treatment, payment, and health care operations (TPO). If Longship is not in-network with your insurance, please be aware claim(s) will be processed as "out of network." _____ (initials).

Any applicable copay, deductible, or coinsurance may be due on the date of service. As needed, invoices will be mailed to patients for any outstanding balances. _____ (initials).

A patient is under no obligation to remain under Longship's care and may choose to terminate the relationship at any time by providing a signed/dated written notice. Longship may choose to terminate the relationship but will provide written notice 60 days prior to effective date. Once a provider-patient relationship has been terminated, all resulting services will cease (prescription refills, renewal of other healthcare services, specialty coordination, referrals, etc.). _____ (initials).

Patients should clearly indicate the purpose of a visit at the time of scheduling to avoid any billing confusion. Longship does not routinely change procedure/diagnosis codes after a visit. Patients are encouraged to ask which codes are likely to be documented before leaving the office if there are any concerns. Preventative visits/annual physicals are intended to be screening in nature and not intended to address new concerns. Addressing new conditions/concerns during a preventative exam typically results in additional charges, which may or may not be covered by insurance. The Medicare Annual Wellness Visit (AWV) is not a routine physical but focuses on preventive care and health risk assessments (it does not include prescription refills, labs, referrals, etc.). _____ (initials).

Credit card information is not routinely stored. Please arrive at every appointment with the appropriate means to tender payment. Major credit/debit cards, personal checks, or cash are accepted. Venmo, PayPal, and other digital type payments are not accepted as many do not meet the government mandated HIPAA/privacy regulations. Longship reserves the right to refuse personal checks after any incidents of non-sufficient funds (aka bounced checks), errors, or late payments. _____ (initials).

Signature: _____ Date: _____

Form effective date Jan. 2026

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Name:_____ Birthdate: _____

NOTICE OF PRIVACY RIGHTS

_____ (initials). I acknowledge I have read and received the Notice of Privacy Rights packet. The copy received is provided for personal records, another copy may be requested at any time.

NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

_____ (initials). I acknowledge I have read and received the Patient Rights and Responsibilities packet. The copy received is provided for personal records, another copy may be requested at any time.

Notice of Agreement

_____ (initials). I acknowledge I have read and received either the Medicare, Commercial Insurance, or Direct Pay Agreement. The original will be kept on file with Longship, a copy may be requested at any time.

Cancellation/No Show/Late Policy

_____ (initials). Longship dedicates time for each individual and strives to respect these appointed times. Situation dependent, a $50.00 fee may be imposed for same day cancellations. Longship reserves the right to reschedule patients who arrive late for any appointment as this may affect another person's allocated time. A no-show to an appointment may be charged $75.00.

AUTHORIZATION REGARDING MESSAGES (PLEASE CHECK ALL THAT APPLY)

□ Longship may leave a detailed message on the preferred contact number's voicemail regarding medical treatment, care, test results, or billing information.

□ Longship may leave a detailed message with any individual listed on the release of information (next page) regarding medical treatment, care, test results, or billing information.

□ Longship or Advanced MD (electronic health record system) may text or call the preferred contact number with automated appointment reminders.

□ Longship may only leave a generic message with a request for return phone call.

TEXT/EMAIL MESSAGE DISCLOSURE

_____ (initials). Texts and emails have become a staple of messaging as a quick and effective method of communication. Texts and email messages are generally not secure and lack HIPAA/Privacy protection requirements. Longship advises against sending protected information by unsecure means. A patient choosing to send a text or email message acknowledges that Longship will not be held liable for any breach of disclosure of private or protected information.

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AUTHORIZATION TO RELEASE INFORMATION

Many patients let other individuals, such as family members, receive or request the patients' medical information (i.e. test results, imaging, billing information, etc.). Under HIPAA, Longship may not give non-emergent information to anyone without patient consent. If you wish other individuals to have access to your health information, please designate below.

***Minors special consideration. Alaska statutes (AS 25.20.025) permit a minor to obtain certain health care services without the consent of a parent or guardian. When a minor opts to have certain services their health information cannot be released to anyone without the consent of the minor.

Longship may release my records and health information to the following individuals. A patient may change these authorizations at any time, Longship requests changes be done in person to verify identity.

_____ Relation to patient: _____

_____ Relation to patient: _____

_____ Relation to patient: _____

_____ Relation to patient: _____

MISCELLANEOUS DISCLOSURES

As of August 19, 2024. Longship contracts with a 3rd party for billing insurance, Guardian Healthcare Solutions. Patients may be contacted by Guardian for billing issues. https://guardian-hcs.com/index.html

Longship contracts with Advanced MD for electronic heath record (EHR) system. Advanced MD offers a secure patient portal and telehealth platform. Telehealth appointments do not require a portal, just a smart device with Zoom.

□ Opting in for a patient portal. Provide email address: _____

Name: _____ Date: _____

Signature: _____

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Today' s Date:

HEALTH HISTORY QUESTIONNAIRE

All information obtained in this questionnaire is confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring provider:	**Date of last physical exam:**

Please list any current specialty providers

☐	Cardiology:	☐	Dermatology:	☐	Orthopedics:
☐	Pulmonology:	☐	Endocrinology:	☐	Behavioral Health:
☐	OB/Gyn:	☐	Gastroenterology:	☐	Urology:
☐	Oncology:	☐	Other:	☐	Other:

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates: Please check boxes of known immunizations, write date if known of most recent, or number received in series	☐ Shingles	☐ Pneumonia
	☐ Hepatitis A	☐ Chickenpox
	☐ Hepatitis B	☐ MMR *Measles, Mumps, Rubella*
☐ Tetanus/Tdap:	☐ IPV/Polio	☐ Covid
	☐ HPV	☐ Influenza

Please check the box for any acute or chronic medical problems, if chronic please write approximate year of diagnosis

☐	Visual changes/loss	☐	Shortness of breath	☐	Acute change in muscle strength
☐	Head injury/traumatic brain injury	☐	Emphysema or COPD	☐	Joint pain/issues
☐	Headaches	☐	Asthma	☐	Back pain/issues
☐	Seizures	☐	High blood pressure	☐	Skin lesions, rashes, precancerous moles
☐	Memory problems/Dementia	☐	Chest pain or angina	☐	Sexually Transmitted Infections
☐	Hearing changes/loss	☐	Heart attack/myocardial infarction	☐	Elevated cholesterol
☐	Recent unintentional weigh loss/gain over 10lbs	☐	Pacemaker/internal defibrillator	☐	Diabetes/Prediabetes/abnormal glucose levels
☐	Throat or swallowing disorders	☐	Abnormal heart rhythm	☐	Thyroid disorder
☐	Allergies	☐	Constipation	☐	Cancer- specify on next page
☐	Recent unintentional weight changes	☐	Diarrhea	☐	Benign tumors/growths/cysts
☐	Gynecologic problems	☐	Difficulty controlling bowel	☐	Difficulty with sleep
☐	Hepatitis A, B or C	☐	Difficulty controlling bladder	☐	Chronic pain – specify on next page

NAME_____ DATE OF BIRTH: _____

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Other problems not listed on prior page or additional information for problems on prior page:

Surgeries		
Year	Reason	Date/Year

Other hospitalizations		
Year	Reason	Date/Year

Have you ever had a blood transfusion?	☐ Yes	☐ No
Please list any problems with blood transfusion:		

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List your prescribed medications/inhalers, over-the-counter drugs, and vitamins/supplements		
Name	Strength/Dose	Frequency Taken

Allergies to medications/Other pertinent allergies	
Name of Drug or Environmental Material	Reaction

NAME_____ DATE OF BIRTH: _____

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HEALTH HABITS AND PERSONAL SAFETY

INFORMATION OBTAINED IN THIS QUESTIONNAIRE IS CONFIDENTIAL, INFORMATION IS USED TO AID IN MEDICALTREATMENT DECISIONS.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
	Any health goals regarding exercise?					
Diet	Are you restricting any food types or food categories, please list restricted foods.				☐ Yes	☐ No
	If yes, is this a provider recommended/medical diet?				☐ Yes	☐ No
	# of meals you eat on an average day?					
	Rank salt intake	☐ High	☐ Med	☐ Low		
	Rank fat intake	☐ High	☐ Med	☐ Low		
	Any health goals regarding diet?					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola/Energy drinks		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what type?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Has a family member or friend expressed concerns about the amount?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
Tobacco	Tobacco products use- current or prior				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Year quit if applicable				
Drugs	Do you currently use recreational drugs, ?				☐ Yes	☐ No
	Have you ever used street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No

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Personal Safety and advanced planning	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Any concerns with ADLs or activities of daily living (personal hygiene, toileting, eating, mobility issues)	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with the provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

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MENTAL HEALTH

Is stress a major concern?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you have panic symptoms when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor or received behavioral health treatment?	☐ Yes	☐ No

OTHER PROBLEMS OR CONCERNS

Please use the space below to list any other concerns:

HEALTH GOALS

Please use the space below to list two short term health goals (6-12 months) and two long term health goals (1-3 years):

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Last 4 Social Security #: xxx-xx-_____

I request and authorize _____
to release healthcare information of the patient named above to:

	Name:	**Longship Nursing and Consulting LLC**	
Mail Address	Fax Phone	PO Box 672154 Chugiak, AK 99567	**Office Fax:** 1-888-892-4144 **Office Phone:** 907-854-6877
	City: Chugiak	State: AK	Zip Code: 99567

The purpose of this request is to aid in continuity of healthcare. I am authorizing release of healthcare records associated with:

☐ Healthcare information relating to the following treatment(s), condition(s), date(s): _____

_____

☐ All healthcare information for dates: _____

☐ 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 venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

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

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

☐ I understand I may revoke this authorization at any time. I understand the information I am authorizing for release may be redisclosed by the recipient and no longer protected by HIPAA privacy rule.

☐ I understand this authorization is voluntary and a refusal to sign the authorization will not affect my ability to obtain treatment.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Longship Nursing and Consulting LLC

PO Box 672154, Chugiak, AK 99567 ⁘ **Ph:** 907-854-6877 ⁘ **Fax:**1-888-892-4144

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Last 4 Social Security #: xxx-xx-_____

I request and authorize _____
to release healthcare information of the patient named above to:

	Name:	**Longship Nursing and Consulting LLC**	
Mail Address	Fax Phone	PO Box 672154 Chugiak, AK 99567	**Office Fax:** 1-888-892-4144 **Office Phone:** 907-854-6877
	City: Chugiak	State: AK	Zip Code: 99567

The purpose of this request is to aid in continuity of healthcare. I am authorizing release of healthcare records associated with:

☐ Healthcare information relating to the following treatment(s), condition(s), date(s): _____

_____

☐ All healthcare information for dates: _____

☐ 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 venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

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

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

☐ I understand I may revoke this authorization at any time. I understand the information I am authorizing for release may be redisclosed by the recipient and no longer protected by HIPAA privacy rule.

☐ I understand this authorization is voluntary and a refusal to sign the authorization will not affect my ability to obtain treatment.

Patient Signature: _____ Date Signed: _____

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