"HIPAA- Privacy Authorization Form

Authorization for use or disclosure of Protected Health Information

Patients Name: ______________________________________ Date of Birth: _______________________

I authorize the following individual(s) to obtain my personal/medical information:

______________________________________ ______________________________________
Name Relationship

______________________________________ ______________________________________
Name Relationship

______________________________________ ______________________________________
Name Relationship

______________________________________ ______________________________________
Name Relationship

I understand and agree to the NSS Notice of Privacy Practices which describes how my protected medical information may be used and disclosed, and may be given a copy if requested.

______________________________________ ____________________
Patient or representative Signature Date

This authorization will expire one year from the date of signing.