

HIPPA Compliance

**Patient Authorization For Practice To Release
Protected Health Information To Third Parties**

For Nao Medical Urgent & Walk-in Medical Care (Nao Medical") & Hicksville Family Medical Care ("HFMC")

By signing this authorization, I authorize Nao Medical/HFMC to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below. This authorization permits Nao Medical/HFMC to use or disclose to

(Person or entity to receive the information) the following individually identifiable health Information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, the origin of information, etc.).

This authorization will expire on **31-Dec-2021** (Expiration date or defined event).

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Nao Medical/HFMC has acted in reliance upon this authorization. My written revocation must be submitted to Nao Medical/HFMC.

Name

Signature

Date