Patient Authorization for Nao Medical to Release Protected Health Information (PHI) to third parties

You can withdraw this consent at any time. By signing this form, I authorize Nao Medical to use and/or disclose certain individually identifiable protected health information (PHI) about me to a designated person or entity including:

Name, address, dates related to an individual -- birthdate, admission date (if applicable), phone number, fax number, email address, medical record number, health plan beneficiary number (if applicable), account number, device identifiers and serial numbers (if applicable), etc.

By signing this form, I am granting permission for the use of my personal data for personalized targeted updates, advertising, and receiving information about discounts or special marketing programs. I understand that these promotional offers about Nao Medical services relevant to my healthcare needs would come to me via email, text message, as well as other electronic means (e.g., but not limited to, phone calls). I understand that in order to personalize my experience with Nao Medical, my personal data would need to be utilized for running these campaigns and targeted outreach to me. I understand that I can withdraw consent at any time by contacting Nao Medical or following instructions in the communication.

When my information is used or disclosed in relation 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 has acted in reliance upon this authorization. My written revocation must be submitted to Nao Medical.