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

For Nao Medical

By signing this form, I authorize Nao Medical to use and/or disclose certain protected health information (PHI) about me to person or entity to receive the following individually identifiable health information

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

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.