

HIPAA Privacy Authorization for Use and Disclosure of Personal Health Information

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations as amended from time to time. You may refuse to sign this authorization.

By my signature below, I acknowledge that I have received and read the Notice of Health Information Privacy Practices. I have been provided a copy of, read and understand NLC's HIPAA Privacy Notice containing a complete description of my rights, and the permitted uses and disclosures of my protected health information under HIPAA. Further, I acknowledge that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and is no longer protected under HIPAA.

Name: _____
Last First MI

Address: _____
Street City State Zip

Date of Birth: _____

Today's Date: _____

For office use only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained.

Reason: _____

Clinician Signature

Date