

HIPAA AUTHORIZATION FORM

Date: _____

Patients Name: _____ D.O.B. _____

Address: _____

_____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____

I, _____, give permission to Nova Medical & Urgent Care Center Inc. to use or disclose my personal health information in the manner described below. I have been told that I am under no obligation to sign this authorization form and that Nova Medical & Urgent Care Center Inc. will not condition treatment or payment on my decision to sign this form. I have signed this form voluntarily.

The following is a description of my personal health information that I authorize to be used and/or disclosed.

The following is a listing of the person(s) and/or organization(s) that I authorize to receive my personal health information as per the limitations listed above. I have been told that if the person(s) and/or organization(s) listed below are not health care providers, a health plan or a health care clearinghouse, that they are not subject to the same Federal privacy rules and that they may disclose my health care information without obtaining my permission.

The following is a description of the purpose(s) for which my health care information may be used and/or disclosed to the previously mentioned person(s) and/or organization(s).

I understand that I may revoke this authorization at any time by asking to complete a revocation form that Nova Medical & Urgent Care Center Inc. will provide me upon request. I understand that such revocation will become effective on the date I complete the request form and will have no effect on the uses and/or disclosures made prior to that date. I understand that I am under no obligation to sign this form but if I do sign it, I must be provided a copy of the signed form.

I understand that prior to signing this authorization form, I have the right to inspect and/or copy the health information which will be used or disclose pursuant to this authorization.

I understand that Nova Medical & Urgent Care Center Inc. will (please check one of the following):

- not receive any direct or indirect payment in connection with the use or disclosure of my health information.
- will receive either direct or indirect payment or remuneration for the use or disclosure of my health information in the amount of \$ _____.

This authorization will expire on _____

Date of Expiration

