AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR NSHC PUBLIC COMMUNICATIONS & MARKETING

Name of individual – please print: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ E-mail address: _____

I authorize Norton Sound Health Corporation (NSHC) to use my information (through interview, photograph, video, or other) for the following marketing and public relations purposes:

☐ All purposes (e.g., newsletters, annual reports, social media, advertisements, etc.)

☐ Specified purpose(s): _____

I understand that the information used or disclosed pursuant to this authorization is not covered by federal privacy regulations, and that any health information disclosed may be re-disclosed and is no longer protected under federal law.

I understand that I do not need to sign this authorization. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services.

To revoke this authorization, please send a written statement {including your full name. address and phone number) stating that you are revoking this authorization to:
Public Relations, Norton Sound Health Corporation, P.O. Box 966, *Nome, AK* 99762

☐ I have read this authorization and I understand it. Unless revoked, this authorization [redacted] (specify either date or event)_____

_____ _____

Individual/Personal Representative **Date**

Personal representative's name (please print):_____

Description of personal representative's authority: _____

For official NSHC Use Only.
Name and title of NSHC employee arranging authorization:_____
Description of interview, photograph and/or videotape: