Northwest Iowa P.C.
Surgeons

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AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION and ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As required by the Health Insurance Portability and Accountability Act of 1996, Northwest Iowa Surgeons, PC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on the form indicates that you are giving permission for the uses and disclosures of protected health information as described in the above notice.

I, _____(print name) hereby authorize the use and/or disclosure for the purpose of carrying out treatment, payment or health care operations.

I understand that information disclosed pursuant to this authorization at any time by giving written notice to Northwest Iowa Surgeons, PC. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign the authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I acknowledge that a copy of Northwest Iowa Surgeons, PC Notice of Privacy Practices was made available to me and /or I received a copy and understand how the practice may use and disclose my confidential information. I further understand that the physician has reserved a right to change his privacy practices that are described in the Notice and a copy will be made available to me of the revision.

Signed:_____ Date: _____
(Parent or Guardian if minor)

Please indicate relationship if not signed by patient: _____

Signed form received by:

Reason Acknowledgment Refused: _____

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