

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

| Name of individual – please p | orint: | |
|--|---|--|
| Address: | | |
| City: | State: | Zip: |
| Phone number: | E-mail address: | |
| I authorize Norton Sound Hea photograph, video, or other) f | | use my information (through interview, and public relations purposes: |
| | vsletters, annual reports, soc | ial media, advertisements, etc.) |
| | s, and that any health informa | ant to this authorization is not covered ation disclosed may be re-disclosed and |
| Y . | _ | Refusal to sign the authorization will ces or reimbursement for services. |
| To revoke this authorization, and phone number) stating the Public Relations, Norton Sound | at you are revoking this auth | |
| and the second s | rization and I understand it. It date or event) | Unless revoked, this authorization |
| Individual/Personal Represo | entative Date | |
| Personal representative's nam | e (please print): | |
| Description of personal repres | sentative's authority: | |
| For official NSHC Use Only. Name and title of NSHC emp Description of interview, pho- | loyee arranging authorizatio | n: |

Revised Date: July 20, 2021