

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization and I do not need to sign this form to receive treatment. I understand I may review and/or copy the information to be disclosed. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person/organization receiving the information.

If I have questions about the disclosure or use of my protected health information, I may contact Susan Marcil, Practice Manager, Norton Medical Center, 14 Taunton Avenue, Norton, MA 02766 or 508-285-9500.

My signature below indicates that I have read and understand the terms of this Authorization and I voluntarily authorize NMC to use or disclose my health information in the manner described.

Signature of Patient: _____ Date: _____

Print legal name of Patient: _____

If patient is a minor or otherwise unable to sign this Authorization:

Signature of Personal Representative: _____

Relationship to Patient: _____ Date: _____