HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1240 S. Parker Rd., Suite 100, Denver, CO 80209 phone 303.219.0030 fax 303.600.7340

This form is for use when such authorization is required and complex with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name: _____

Date of Birth: _____ **Phone:** _____

I authorize Lighthouse Complex Care to **receive or disclose** the following health information:

____ Any/All of my health information

____ Health information between the following dates: _____ to _____

_____ Other_____

You may disclose my health information to, or receive it from:

Name/Title of Organization: _____ Phone: _____

Address: _____City, ST, ZIP _____

Reason(s) for this authorization:
(.) At my request. (.) Transfer of information (.) Specialist referral. (.) Insurance/Attorney

(.) Other: _____

Name/Title of Organization: _____ Phone: _____

Address: _____City, ST, ZIP _____

(.) At my request. (.) Transfer of information (.) Specialist referral. (.) Insurance/Attorney

(.) Other: _____

My Rights: I understand I do not have to sign the authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization for to take part in a research study or to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do revoke , it will not affect any actions already taken by the practice or any practice acting on the this authorization. I may not be able to revoke this authorization if tits purpose was to obtain insurance.

Once the office discloses this health information, the person or organization who receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient Signature and Printed Name Date and Time

Witness Signature:

Date & Time: