# LIGHTHOUSE HEALTHCARE, LLC

Request for access to/Authorize for Use and Disclose of Protected Health Information

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____- _____ - _____ ADDRESS: _____
MO DAY YR CITY ST ZIP

DAYTIME PHONE: (___)_____ EVENING PHONE: (___)_____

Information authorized to be released: ALL MEDICAL RECORDS pertaining to the above named patient.

Authorized Release from: _____
Name of facility

_____
Address of facility

_____
Phone# Fax#

Disclose to: Lighthouse Healthcare

_____
Address of Facility

_____
Phone# Fax#

□ I authorize Lighthouse Healthcare to disclose my Protected Health Information to the following:

_____ _____
Name of facility Phone#

_____ _____
Address Fax #

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I specifically authorize the release of information relating to:
___ Substance abuse (including alcohol/drug abuse)
___ Mental health or behavioral health
___ HIV related information (AIDS related testing)
X _____
Signature of Patient / Personal Representative Date

Purpose of Disclosure:
___ Changing Physician ___ Consultation
___ Insurance/ WC ___ School
___ Research
___ Legal (specify) _____
___ Other (specify) _____

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- I understand the expiration date of this consent expires on: _____
- In the event no date, event or condition is specific for expiration, this consent expires in ninety (90) days from the signing.
- I understand that the services are NOT contingent upon or influences by my decision to permit the information release.
- I also understand that I may revoke this in writing at any time unless action has already been taken upon it. I freely and voluntarily give this consent.
- I understand that the records may be protected under 42 C.F.R Part 2, governing Alcohol and Drug Abuse patient records requested, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. provided by regulations, State Confidentiality laws and regulations, and cannot be released without my consent unless otherwise permitted by such regulations. State and Federal law regulations prohibit further disclosure of such records without my specific written consent or when otherwise permitted by such regulations.
- The information I authorize for release may include records which may indicate presence of a communicable or venereal disease which may include, but no limited to diseases such as Hepatitis, Syphilis, Gonorrhea and Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome.

I acknowledge and understand the terms of this Request for access to/Authorize for Use and Disclose of Protected Health Information

_____ _____
Signature of Patient/Legal Representative Date

_____
Relationship to Patient