Documents for Signature

I Agree and Accept: Healthcare Rights

Authorization for Use or Disclosure of Protected Health Information

Required by the Health Insurance Portability and Accountability (HIPAA) Act 45 G 5 R Parts 160 and161

1. I authorize LGTC Group to use certain forms of convenient, but non-encrypted, data transmission services and platform to transmit or receive my protected health information when using any web-based forms that are on the LGTC website or linked to the LGTC website (the "web-based Forms"). The intended recipients that I am authorizing to access my protected health information through these web-based Forms include any LGTC employee, practitioner or contractor who may need access to this information for treatment, coordination of care, payment, billing. or administrative purposes. These web-based Forms are convenient, but because they may not at all times he encrypted, I understand that my protected health information could be intercepted by someone other than the intended LGTC recipients if I consent to the use of these web-based forms by my signature below.
2. This authorization for release of information covers the period of healthcare from all past, present, and future periods.
3. I authorize the release of my complete health record and any related information I may provide to LGTC through these web-based forms (including records, if such exist, relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
4. This medical information may be used for treatment, coordination of care, payment, billing, administrative, or any other purposes as I may direct.
5. This authorization shall be in full force and effect until six months from the date l terminate my agreement to use LGTC services, at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. l understand that information used or disclosed pursuant to this authorization may be disclosed by any recipients and may no longer be protected by federal or state law.

Signature: I acknowledge I have read and understood the content of the forms.