

LIGHTHOUSE NURSING, INC

HIPAA

This notice describes how health information about you may be used and disclosed. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I authorize LightHouse Nursing the use and disclosure of my health information. I understand that this will be used by LightHouse Nursing and its clients to evaluate my qualifications for employment opportunities as it relates to the healthcare field. This information may also be used for workers compensation and similar programs, and/or when necessary to reduce or prevent a serious threat to your health and safety, or health and safety of others. We will only make disclosures to a person or organization able to help prevent the threat.

I further understand that if a person that receives this information is not a healthcare provider, the information disclosed may be re-disclosed and no longer protected by regulations. I understand that I may revoke this authorization at any time by sending a written request to LightHouse Nursing, except to the degree that action has been taken in reliance on upon this authorization.

This authorization will expire one year from the dated signature below.

Signature _____

Date _____