

Lindstrom Insurance
Cal-GLBA/HIPAA "Opt-In" Authorization Form

Phone: 831-335-5812 Fax 831-335-5883

This form authorizes release and disclosure of Non-Public Personal Information, Non-Public Personal Financial Information and Protected Health Information (NPI, NPFI, and PHI) to the person or entity authorized to receive information indicated below.
Additional forms from insurance carriers may also be required.
You may wish to retain a copy of this document for your records.

Information about PHI, NPI, and NPFI disclosure

I/we hereby authorize the use or disclosure of my/our individually identifiable information as described below. I understand that this authorization is voluntary and that I may refuse to sign this authorization. The authorization may be revoked at any time by submitting my revocation in writing to Lindstrom Insurance. Consent will remain in effect until revoked or modified in writing.

Person/Entity Authorized

to Disclose Information: All Licensed Agents and All Service Personnel of Lindstrom Insurance

Person/Entity Authorized

to Receive Information: Employees and representatives of my Medical, Dental, Life, Disability, or Long Term Care Insurance Company or Health Plan (HMO), Chiropractic/Acupuncture Plan, Employee Assistance Plan, Third Party Administrator, General Agent, Service Provider, such as Hospital, Laboratory, Physician, Dentist, Chiropractor, or Acupuncturist. In addition, information may be released to family members or other representatives named below: (Please print legibly.)

-----, -----
Spouse Parents (for minor children)

Other representative (such as your attorney, domestic partner, office manager, etc.)

Secure Answering Device or Voicemail Number (if you wish to allow messages with specifics)

Specific Purposes for Use And Disclosure:

We will use your information for the underwriting process, claims assistance, billing problems, personal assistance and other requests you may make.

Specific Information to be

Used or Disclosed:

We may disclose all information collected about you needed to service and underwrite your account including Personal Health Information (including but not limited to medical charts, diagnosis information, provider utilization, dates of service, lab results and summary data), Health Claim Information (including but not limited to dates of service, providers, claim action and claim status, ID number(s), amounts billed and paid), HMO or Insurance Carrier Information

Except: _____

Dates of Information to

be Used or Disclosed:

- No date restrictions
- Specific Dates _____

Important Information About Your Rights

I have read and understand the following statements about my rights:

1. I may revoke this authorization at any time by notifying Lindstrom Insurance in writing, but revocation will not have any affect on any actions or release of information Lindstrom Insurance took before receiving the revocation.
2. If this authorization is revoked, it is my responsibility to notify any parties to which information has been disclosed of the revocation of this authorization.
3. I may request to review and copy this form and/or the information described in or released by this form. My authorized representative is entitled to receive a copy of the form.
4. I understand that health care benefits, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
5. The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity and may be no longer protected under federal or state privacy regulations. I have the right to seek assurances from the above named persons/organizations authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.
6. Lindstrom Insurance will maintain this document or a true and correct copy, as will the financial institutions to whom it may be released.

Authorization

I authorize the identified persons/organizations to receive and release the Protected Health Information, Non-public Personal Information and Non-public Personal Financial Information as described above. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information. The release of this information will be for the purposes indicated above. Such purposes typically include reviewing personal health and financial information and health claims information, interacting or corresponding with claims and other service personnel of the insurance company, HMO, or Third Party Administrator, interacting or corresponding with healthcare personnel or providers to the extent they are necessary to assist the patient. A fax or electronic copy of this authorization shall be as valid as the original.

Unless otherwise revoked or modified in writing above, this authorization will remain in effect. HIPAA regulations may require a new authorization each time I change insurance carrier, or every 12months. I acknowledge that I have received or retained a copy of this authorization. I hereby release Lindstrom Insurance from all liability and all claims of any nature whatsoever pertaining to disclosure of the information in acting upon this authorization. I understand the Notice of Privacy Practices details privacy use and disclosure procedures and that a copy may be obtained from Lindstrom Insurance.

Signature and Acknowledgement

Note: Results of claims inquiries, underwriting status, and answers to questions regarding minor children may only be released to the parent(s) signing this form. If you wish to have information about one spouse released to the other spouse, then both must sign this form. Please include the name of your employer if your insurance is through a group.

Employer Group Name: _____

Printed Names: _____

Signatures: _____

Date Signed: _____

Mother's Middle Name (for identification purposes):

If you prefer, you could give us the name of the High School you attended rather than your mother's middle name We may use this information to identify you when you phone our office for assistance.