HIPAA MEDICAL INFORMATION RELEASE AUTHORIZATION

(Valid under Code of Federal Regulations volume 45, sections 164.502(a)(1)(iv) and 164.508)

I understand that the Health Insurance Portability and Accountability Act ("HIPAA") limits disclosure of my protected medical information. I am signing this authorization because it is crucial that my health care providers readily give my protected medical information to the people listed in this document or my Medical Power of Attorney or my Durable [Financial] Power of Attorney so that we can discuss it and I can obtain their advice.

I, _____, hereby authorize _____
_____

OR

all covered entities as defined by HIPAA, including but not limited to a doctor (including but not limited to a physician, podiatrist, chiropractor or osteopath), psychiatrist, psychologist, dentist, therapist, nurse, hospital, clinic, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, any other health care provider or affiliate or medical insurance company to disclose

_____
_____

(except_____)

OR

all health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future, and any other information which is in any way related to my health care

to the individuals named in my Medical Power of Attorney, my Durable Power of Attorney and _____.

This disclosure shall include answering questions and discussing the protected medical information with the person or entity which has it even if I am fully competent to ask questions and discuss the protected medical information.

Termination. This authorization shall terminate on the earlier of (1) the second anniversary of my death or (2) receipt of my written revocation by certified mail, return receipt requested, or facsimile confirmation or any other electrical or physical document showing actual receipt except to the extent that the recipient has acted based on this HIPAA release.

Re-disclosure. I understand that the people receiving the protected medical information might disclose it to others and that once disclosed the information will no longer be protected by HIPAA law and regulation. No one receiving the information may be required to indemnify a health care provider or insurer or to take any action in order for it to comply with this authorization.

Waiver and release. I hereby release any entity which acts in reliance on this authorization from any liability which may accrue from releasing my protected medical information and subsequent action taken by my authorized persons.

Instructions to my authorized persons. My authorized persons shall have the right to bring a legal action in any applicable forum against any applicable entity which refuses to recognize and accept this authorization. My authorized persons may sign any documents they find appropriate to obtain the protected medical information.

Valid document. A copy or facsimilie of this document shall have the same effect as the original.

Signed this ___ day of _____ in the year ____

By_____ Date of Birth_____

_____
[PLEASE PRINT YOUR FULL NAME]