HIPAA AUTHORIZATION AND RELEASE

Name: _____ Date of Birth: _____ SSN: _____

For purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 2024) and the Regulations promulgated thereunder, I hereby designate, effective immediately, the following person as my agent and "Personal Representative":

Name: _____ Telephone Number: _____

Address: _____ E-mail Address: _____

_____

Legal Representative (if applicable): _____

I authorize the following health-care provider or other covered entity to disclose to my agent, on my agent's request, information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, including what is otherwise private or protected individually identifiable health information and medical records regarding my past, present, or future medical or mental health care or condition (the "Information"): *(initial your choices)*

_____ any and all Information

_____ Information from the period of _____ to _____

_____ Information related to a specific treatment or medical condition (specify):

_____

_____ Information relating to sexually transmitted disease,

_____ Information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV)

_____ Information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Name of Entity: _____

Address: _____

_____

Telephone Number: _____

E-mail Address: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will remain in effect until one (1) year from the date of this authorization. I have a right to receive a copy of this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment or eligibility or enrollment for benefits. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the releaser indicated above.

I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

DATED:_____ _____

Signature of Patient or Legal Representative

Subscribed and sworn to before me

this ____day of _____, 20___.

_____

NOTARY PUBLIC

This Authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA"), 45 CFR Parts 160 and 16.

Copies have the same force and effect as the original.

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