

Authorization to Disclose Protected Health Information

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____

Appointment of HIPAA Personal Representatives

ALL of the persons, class of persons or entities designated below (indicated by a checked box) are authorized to receive my Protected Health Information:

- The Agent(s) and Successor Agent(s) appointed under my Advance Health Care Directive or Durable Power of Attorney for Health Care
- The Trustee(s) and Successor Trustee(s) appointed under my Revocable Living Trust or any other trust I have created during my lifetime.
- The Agent(s) and Successor Agent(s) appointed under my Durable Power of Attorney for Property
- The following named individuals: (No. of Boxes Checked Below ____)

The person(s) or entity(ies) named above shall have the status, power, authority, rights and title as my Personal Representative(s) for all purposes as provided in the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), Pub. L. 104-191, 45 CFR §§ 160–164.

I direct each health care provider or Covered Entity to release to my Personal Representative any and all Protected Health Information as may be requested and deemed necessary by my Personal Representative in order for my Personal Representative to perform his or her duties.

I authorize my Personal Representative to execute any and all releases and other documents necessary in order to obtain disclosure to my Personal Representative of my patient records and other Protected Health Information that may be subject to and protected under HIPAA.

I authorize my Personal Representative to appoint a Patient Advocate for me, who may be any person so designated by my Personal Representative. My Patient Advocate shall have the same right to ask questions and receive information regarding my medical condition(s), treatment, and any proposed treatment as I and my Personal Representative would have, and the right to be in attendance to me at all times.

I authorize my Personal Representative to take any and all legal steps to ensure compliance with my instructions to provide access to my Protected Health Information. Such steps shall include resorting to any and all legal procedures in an out of the courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorney fees against anyone who does not comply with this Authorization to Disclose Protected Health Information or my Advance Health Care Directive / Durable Power of Attorney for Health Care.

I understand that once my Protected Health Information is disclosed pursuant to this Authorization to Disclose Protected Health Information, it is possible that it will be no longer protected by applicable federal medical privacy regulations and could be re-disclosed by the person(s) or entity(ies) that receive it. I further understand that federal or state law may restrict re-disclosure of HIV / AIDS information, mental health information, and drug / alcohol abuse diagnosis, treatment, or referral information. Except as deemed necessary by my Personal Representative, I do not authorize such secondary disclosure of my Protected Health Information.

I understand that my Personal Representative may be receiving compensation for acting in the capacity designated above and may be compensated for obtaining my Protected Health Information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain medical treatment, or payment, or eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time. This Authorization to Disclose Protected Health Information shall expire one year after my date of death, unless it is revoked earlier.

