GRANT OF AUTHORITY AND AUTHORIZATION
FOR RELEASE OF HEALTH INFORMATION UNDER HIPAA

I, _____, an individual, hereby appoint the following named individual or individuals as my Personal Representative for health care disclosure under the Standards for Privacy of Individually Identifiable Health Care Information (45 C.F.R. §160 and §164) of HIPAA:

_____

_____

_____

I authorize any and all covered entities who are subject to HIPAA regulations, including but not limited to health care professionals such as physicians, dentists, nurses, pharmacists, and health care providers, hospitals, clinics, medical care facilities, laboratories, pharmacies, health plans, insurance companies, the Medical Information Bureau Inc. or other health care clearing houses that have provided services or treatment to me, or that have paid for or are seeking payment from me for such services, or that have provided health care operations for me, to use, release and disclose, without restriction, all of my individually identifiable health information in accordance with and as authorized by HIPAA, including, but not limited to past, present, or future reports or records concerning any past, present, or future medical or mental health condition, history, diagnosis, prognosis, treatment, testing, billing information, identity of health care providers and any other information which is in any way related to my health care.

Additionally, this Authorization shall include the ability to ask questions and discuss protected health information with the covered entity that has possession of the protected health information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full Authorization for access to, use, release and disclosure of ANY protected health information by or to the Personal Representative named in this Authorization as if each person were me.

The authority given my Personal Representative shall supersede any prior agreement that I may have made with my covered entities to restrict access to or disclosure of my individually identifiable health information.

The Authorization is not affected by, and shall not terminate by reason of, my subsequent disability or incapacity. This Authorization shall terminate one (1) year following my death.

Additionally, I understand that I have the right to revoke this Authorization at any time and that any revocation of this Authorization must be in writing, expressly referring to this Authorization. Such revocation shall be effective upon the actual receipt of the notice by the covered entity, except to the extent that the covered entity has taken action in reliance on it. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt

evidencing actual receipt by the covered entity.

By signing this Authorization, I acknowledge the potential that the information used, disclosed or released pursuant to this Authorization may be subject to re-disclosure by the Personal Representative of this Authorization and the information once disclosed will no longer be protected by the rules created in HIPAA. No covered entity shall require my Personal Representative to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this Authorization.

My Personal Representative shall have the right to bring a legal action in any applicable forum against any covered entity that refuses to recognize and accept this Authorization for the purposes that I have expressed. Additionally, my Personal Representative is authorized to sign any documents that the Personal Representative deems appropriate to obtain the use, release and disclosure of the protected medical information.

A copy or facsimile of this original Authorization shall be accepted as though it is an original document.

I hereby release any covered entity that acts in reliance on this Authorization from any liability that may accrue from the use, release or disclosure of my protected medical information in reliance upon this Authorization and for any actions taken by my Personal Representative.

In the event that any provision of this document is invalid, the remaining provisions shall nonetheless remain in full force and effect.

I understand that I have the right to receive a copy of this Authorization.

Dated: _____ _____

Principal

(ATTACH ACKNOWLEDGMENT BY NOTARY PUBLIC)