Authorization to Disclose Health Information

Name: ____

Address: ____

City: ________________ State: ________________ Zip Code: ____________

Telephone: ____

Article One - Recitals and Terms

Section 1. Designation of Personal Representatives.

I authorize all health care providers, including physicians, nurses, hospitals and all other persons and entities ("Covered Entities") who may have provided, or be providing, me with any type of health care, to disclose my Protected Health Information to the following parties and for the stated purposes, who shall have the status, power, authority, rights and title as my Personal Representative for all purposes as provided in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. L. 104-191, 45 CFR §§ 160–164:

a. Individuals

To the following person(s) for any health related purposes:

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

b. Agent under Advance Health Care Directive

The agent and successor agents under my advance health care directive for any health related purpose.

c. Agent under Power of Attorney

The agent and successor agents under my durable power of attorney for property for the purpose of determining my capacity as defined in the power of attorney or by governing law.

d. Trustee

The Trustee and Successor Trustees under any trust for which I am serving as trustee or for which I am a beneficiary for the purpose of determining my capacity as defined in the Trust instrument or by governing law.

e. Partner

To any partner of any partnership or limited liability company of which I am a partner or member for the purpose of determining my capacity as defined in the governing instrument or by governing law.

f. Attorney

To my attorney for the purposes determining my capacity to make lifetime gifts, to execute business and estate planning documents, and whether, and to what extent, a conservatorship of my person or estate or other protective proceeding is necessary or desirable.

g. Guardian Ad Litem

To my guardian ad litem, if one is appointed for me, for the purpose of determining whether, and to what extent, a conservatorship of my person or estate or other protective proceeding is necessary or desirable.

h. Receive Protected Health Information

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

i. Execute Releases

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.

j. Appoint Patient Advocate

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.

k. Assure Compliance

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 and 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.

Article Two - Acknowledgments

Section 1. Re-Disclosure of Protected Health Information.

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. As California law prohibits the further disclosure of my

Protected Health Information without a new authorization, it is my intention that this authorization form be construed to be a new authorization that meets the requirements of California Civil Code §§ 56.11 – 56.13 to permit further authorization by recipients of information initially received under this authorization.

Section 2. Compensation.

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.

Section 3. Refusal to Sign.

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.

Section 4. Revocation.

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

Article Three - General Provisions

Section 1. Effective Immediately.

This Authorization Form is effective immediately.

Section 2. Expiration.

This Authorization Form will continue to be effective until the sooner of its revocation by me or until two years after my death.

Section 3. Durable.

This Authorization Form will continue to be effective even though I become incapacitated.

Section 4. Photocopy.

A photocopy or facsimile copy of this Authorization to Disclose Protected Health Information shall have the same effect as the original.

Article Four - Execution

By signing below, I acknowledge I have read and understand this Authorization to Disclose Protected Health Information.

Date: ________________________ ______________________________________

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA

SS

COUNTY OF _______________________)

On ___________________________, before me, ____________________________, a Notary Public, personally appeared ___________________________________, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _______________________ (Seal)