

## HIPAA RELEASE AND AUTHORIZATION

I, \_\_\_\_\_, hereby authorize the following person to act as my agent with regard to the matters specified in this Release:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

If the person designated as my agent is unable or unwilling to serve, I designate the following persons as my agent hereunder, who shall serve in the following order:

A. **First Alternate Agent**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

B. **Second Alternate Agent**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

This Release and all of the provisions contained herein are effective immediately. I intend for my agent to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This Release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d and 45 CFR 160-164.

### AUTHORIZATION

I hereby authorize any doctor, physician, medical specialist, psychiatrist, chiropractor, health-care professional, dentist, optometrist, health plan, hospital, hospice, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, pathologist, or other provider of medical or mental health care, as well as any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has paid for or is seeking payment from me for such services (referred to herein as a "covered entity"), to give, disclose and release to my agent who is named herein and who is currently serving as such, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis

and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical 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 to any protected medical information to my agent.

In determining whether I am incapacitated, all individually identifiable health information and medical records shall be released to my agent, including any written opinion relating to my incapacity that my agent may have requested. This release authority applies to any information governed by HIPAA and applies even if my agent has not yet begun serving as my agent.

The authority given to my agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to my agent may be subject to redisclosure by my agent and may no longer be protected by HIPAA.

### **TERMINATION**

This Release shall terminate on the first to occur of: (1) two years following my death, or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, electronic mail, or any other receipt evidencing actual receipt by the covered entity. This Release shall not be affected by my subsequent disability or incapacity. There are no exceptions to my right to revoke this Release.

### **RELEASE**

Each covered entity that acts in reliance on this Release shall be released from liability which may result from disclosing my individually identifiable health information and other medical records.

### **LEGAL ACTION**

I authorize my agent to bring a legal action against a covered entity which refuses to accept and recognize this Release. Further, in order to fulfill my intent as expressed herein, I authorize my agent to sign any documentation that my agent deems necessary or appropriate in order to secure the disclosure of my individually identifiable health information and other medical records.

**SUBSEQUENT DISCLOSURE OF INFORMATION**

Any information disclosed to my agent pursuant to this Release may subsequently be disclosed to another party by my agent. My agent shall not be required to indemnify a covered entity or perform any act in the event information is subsequently disclosed by my agent.

**COPIES AND FACSIMILES**

Copies or facsimiles of this Release shall be as valid as the original Release.

I sign my name to this Release on \_\_\_\_\_, 2018, at  
(City, County, State)

\_\_\_\_\_  
Principal

**SIGNATURE OF FIRST WITNESS**

Witness Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_, 20\_\_

**SIGNATURE OF SECOND WITNESS**

Witness Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_, 20\_\_