AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION TO AGENT(S) UNDER HIPAA AND CALIFORNIA LAW

I, ____, grant to
Principal Name & Address

____, my agent
Agent Name & Address

and the following successor agent(s):

____,
Successor Agent Name & Address

____,
Successor Agent Name & Address

____,
Successor Agent Name & Address

the authority to receive information regarding my health care needs, and to advocate for my health care needs, except as may be limited by my advance health care directive (if any), even if I have not been determined to lack capacity.

This release shall apply to any of my information which is governed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC §1320d and 45 CFR pts 160, 164, and California law. I intend my agent to be dealt with by all my health care providers, as required by HIPAA and California law, in the exact same way as I would be treated with respect to my rights regarding the use and disclosure of my identifiable protected health information or other medical records.

Pursuant to HIPAA and California law, I authorize any covered entity, including, but not limited to, any physician, health care professional, dentist, health plan, hospital, nursing home, clinic, laboratory, pharmacy, or any other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking to be paid for services, to give, disclose, and release to my agent and successor agent(s) named above, without restriction and at the request of my agent and successor agent(s), all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including, but not limited to, any and all information relating to the diagnosis and treatment of sexually transmitted diseases, mental illness (including information contained in mental health records protected by the Lanterman-Petris-Short Act), HIV/AIDS, and drug or alcohol abuse.

Any agent named herein shall be treated as my "legal representative," under California Civil Code §56.11(c)(2) for purposes of authorizing disclosure of medical information, and as my “health care agent” for purposes of the California Probate Code, including but not limited to §§4678, 4732, and 4733.

I may revoke this authorization at any time by written notice to the covered entity;

This authorization shall expire on the date of my death unless validly revoked prior to that date.

The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign an authorization unless the law allows conditions;

Under California law, all recipients of protected health care information may not redisclose it except as required or permitted by law.

Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA regulations.

This authority 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.

I have a right to a copy of this authorization.

Date: _____/_____/ 2006 ____

Principal Name (Printed)

____

Signature of Principal

ACKNOWLEDGMENT

State of California)
) ss
County of ______________________________)

On _____/_____/ 2006, before me, ____, a Notary Public, personally appeared

____, personally known to me (or 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.

Witness my hand and official seal.

[SEAL]

____
Signature of Notary Public

____
Notary Public Name (Printed)