**Authorization to Release Health Information and/or Medical Records Protected under the Health Information Portability and Accountability Act (HIPAA)**

I, __, Date of Birth __, Social Security No. __, am the patient and I authorize the disclosure and use of the designated health information as listed on this form. I authorize the custodian of this health information to permit the person or persons named in this form to review or inspect the health information. I also authorize the custodian of the HIPAA-protected health information to provide copies of the information to the named person or persons if requested to do so.

Provide a specific and explicit description of the information to be released, including the date and place of service if applicable:

Any and all of my health information and medical records protected under the Health Information Portability and Accountability Act (HIPAA), dated at any time, and at any place of service, including but not limited to the following:

_____
_____
_____
_____

I authorize the following health care provider or custodian of records to release and disclose the described health information:

My primary health-care physician(s), any individual or institution providing treatment to me, any business holding my health information, and any recipient of this authorization, including but not limited to the following:

_____

I authorize the health care provider or records custodian to release and disclose the health information to my designee:

My health care agent and alternate health care agent, regardless of whether they are actively acting as my agent, including but not limited to:

_____

This request is for the following purpose(s):

___ Personal injury litigation
___ Other pending litigation
___ Medical malpractice litigation
_X_ Other (describe): To serve or to potentially serve as my acting health care agent.

My designee ___ is ___ is not authorized to disclose the described health information to others.

I have the right to revoke this Authorization, in writing, at any time by notifying the person named as my designee to request the information. I shall also notify any health care provider or records custodian named on this form. Any revocation shall be prospective in nature



_____

and shall not affect any actions taken by the designee or health care provider or records custodian prior to the date those persons or entities received the written revocation.

My health care provider cannot require me to sign this Authorization as a condition of providing medical treatment or continuing to provide medical treatment.

This Authorization expires on _____, or when the following event occurs: _____.

_____ _____
Signature of Patient/Authorized Representative Date

Authority of Representative:
___ Patient is a minor and I am the patient's parent and natural guardian.
___ Patient is a minor and I am the patient's guardian, appointed by _____.
___ Patient is a ward and I am the patient's guardian, appointed by _____.
___ Patient is deceased. I am the patient's domestic partner, surviving spouse, executor, or administrator of the patient's estate, appointed by _____.
___ I am the patient's agent, designated in the patient's Health Care Power of Attorney.
___ I am the patient's attorney-in-fact, with the power to make the foregoing request under the terms of the patient's Durable General Power of Attorney and/or Durable Power of Attorney for Finances.
___ Other: _____.

This Authorization to Release Health Information and/or Medical Records is meant to conform to the requirements of a valid authorization as set forth in the Standards for Privacy of Individually Identifiable Health Information (the HIPAA Privacy Rule), 45 C.F.R. Parts 160 and 164. Section 164.508 describes these requirements.

**A PHOTOCOPY OR FACSIMILE OF THIS AUTHORIZATION SHALL HAVE THE SAME EFFECT AS THE ORIGINAL DOCUMENT.**

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The person making this authorization may use the following space to record the names of those individuals, institutions, and health care providers to whom he or she has given copies of this authorization.

Attorney Scott E. Mickelson, P.O. Box 259125, Madison, Wisconsin 53725-9125.
_____
_____
_____
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