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HIPAA AUTHORIZATION UNDER 45 CFR §164.508

Authorization to Disclose Health Information

I, _____, an individual, intend for each of my personal representative(s), _____, _____, _____, and _____, to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. It is my intention to waive the requirement that my personal representative(s) be given only the "minimum necessary" information, and it is my express intent that my personal representative(s) named herein have full and unfettered access to any and all information related in any way to my health care. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164. I desire such information be released at the request of my personal representative.

This Authorization to Disclose Health Information is intended to be a "valid authorization," as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended, and in regulations promulgated thereunder, including, without limitation, 45 C.F.R. §164.508, or any successor regulatory provision.

I hereby authorize:

- any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company, 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 payment from me for such services except as may be specifically limited below:

  _____

- to give, disclose and release to my personal representative(s), without reservation,

- all of my individually identifiable health information and medical records regarding any past, present or potential future medical or mental health condition, to include, but not be limited by, all information related to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and the mental health records protected by the Lanterman-Petris-Short Act, and drug or alcohol abuse, except as specifically limited below:

  _____

The authority given my personal representative(s) 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.

This authorization shall terminate on the first to occur of: (1) Two (2) years after my death; or (2) Upon my written revocation actually received by the covered entity.

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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. This 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 this Authorization.

By signing this Authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the person or persons named in this authorization and the information once disclosed will no longer be protected by the rules created in HIPAA.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing such information except as specifically required or permitted by law.

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

Signed this ____ day of _____, 2009.

_____

Sign above the line and print your name below it

WITNESS STATEMENT:

We declare that _____, signed this document in our presence. We are not appointed as his or her personal representatives by this document, nor are we his or her health care provider or employees of his or her's health care provider. We further declare that we are not related to _____ by blood, marriage, or adoption.

Sign: _____ Sign: _____

Print:_____ Print: _____

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