HIPAA RELEASE AND AUTHORIZATION FORM

I, [_____]., residing at [_____],
NAME ADDRESS

authorize any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered healthcare provider, any insurance company and the Medical Information Bureau Inc. or other healthcare clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to the agent(s) as hereinafter described, 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.

The persons designated as my agents for purposes of this agreement are as follows:

- **All person(s) designated as healthcare agent(s) or alternative healthcare agent(s) in any Power of Attorney for Healthcare or similar document executed by me;**
- **All person(s) designated as my attorney-in-fact and/or agent and their successors under any Durable Power of Attorney or similar document executed by me;**
- **All person(s) designated as trustee(s) and/or successor trustee(s) under any revocable or living trust executed by me.**

The authority given my agent(s) shall supersede any prior agreement that I may have made with my healthcare providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my healthcare provider.

I intend for my agent 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. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (a/k/a HIPAA), 42 USC 1320d and 45 CFR 160-164, and all other applicable state and federal law.

Dated:

_____ _____
Witness **[NAME]**

_____
Witness