HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

I, make this Authorization to Release Medical Information ("Authorization") to designate the individuals authorized to receive my Medical Information and to authorize my Health Care Providers to release my Medical Information to those designated individuals. I authorize my Health Care Providers to disclose and release my Medical Information to any or all of my Personal Representatives:

Primary health care representative;

Backup health care representative;

Any representative named under my health care directive or other medical or health care power of attorney.

It is my intention to provide the Personal Representatives named above broad rights to access and receive my Medical Information. Despite the provisions of HIPAA, I desire my Personal Representatives to have access to my Medical Information, at the request of my Personal Representative. This Authorization constitutes a full authorization to disclose any Individually Identifiable Health Information to the Personal Representatives named in this Authorization.

I intend this Authorization to be broad and any questions or ambiguities regarding the provisions of this Authorization shall be resolved in favor of allowing the disclosure and release of my Medical Information to my Personal Representatives.

This Authorization is effective immediately upon my execution of this Authorization. This Authorization is durable and shall remain effective regardless of subsequent disability or incapacity. This Authorization shall terminate upon my written revocation received by my Health Care Provider or 24 months after my death, whichever occurs first.

This Authorization is in addition to and does not revoke or supersede any other authorizations I have granted in the past or may grant in the future. This Authorization does not replace any Advance Health Care Directive or medical power of attorney and any actual or perceived conflict with such documents does not affect the validity or scope of this Authorization. I reserve the right to revoke this Authorization in writing.

Any person authorized to receive my Medical Information may bring a legal action against any Health Care Provider that fails to accept this Authorization or refuses to provide my Medical

Information for any purpose authorized by this Authorization. I acknowledge that my Medical Information may not be protected by HIPAA after disclosure to my Personal Representatives and that my Medical Information may be re-disclosed by my Personal Representatives.

I, , sign my name to this instrument and declare that I execute it as my free and voluntary act for the purposes expressed therein.

Signature: **Signature Date:**