HIPAA AUTHORIZATION FORM

45 – C.F.R. #164.508

STATEMENT OF INTENT:

It is my understanding that Congress passed a law entitled "Health Insurance Portability and Accountability Act of 1996" also known as HIPAA. There are federal regulations that interpret and implement that law. HIPAA limits disclosure of my individually identifiable health information to certain family members and friends, regardless of my state of health. I am signing this authorization so that my healthcare provider can disclose my healthcare information to the persons listed and openly discuss that information with them.

AUTHORIZATION:

I,_____, hereby authorize my physicians, nurses, hospitals and other healthcare providers to fully disclose my individually identifiable health information to any or all of the following authorized persons designated as my personal representatives.

NAME: _____

ADDRESS: _____

PHONE: _____

NAME: _____

ADDRESS: _____

PHONE: _____

NAME: _____

ADDRESS: _____

PHONE: _____

Printed Name:_____ **DOB:**_____

AUTHORITY TO DISCUSS AND ANSWER QUESTIONS:

My healthcare providers are expressly authorized to answer questions posed by the personal representatives listed above and openly discuss with them my condition, treatment, test results, prognosis, and everything pertinent to my healthcare, even if I am fully competent to ask questions and discuss this matter at the time. This document constitutes a full authorization to disclose any individually identifiable health information to the personal representatives named in this authorization.

WAIVER AND RELEASE:

I hereby release any healthcare provider that acts in reliance on this authorization from any liability that may accrue from releasing my individually identifiable health information and for any actions taken by my personal representatives.

TERMINATION:

This authorization is effective as of the date shown as the date of its signing and shall not be affected by my subsequent disability or incapacity. This authorization shall terminate on the first to occur of

1. two years following my death, or
2. upon my written revocation actually received by the healthcare provider. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile or any other receipt evidencing actual receipt by the healthcare provider.

REDISCLOSURE:

By signing this authorization, I readily acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the personal representative(s) named in this authorization and no longer be protected by HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-healthcare professionals and otherwise cause me and my family various forms of injury. I fully indemnify my healthcare providers for all consequences which may occur as a result of their good faith reliance and compliance with this authorization. No healthcare provider shall require my personal representatives to indemnify the healthcare provider or agree to perform any act in order for the healthcare provider to comply with this authorization.

CONFLICTS WITH OTHER AUTHORIZATIONS:

This authorization is in addition to other medical release authorizations I may have granted in the past or future. It does not replace them. This authorization may be relied upon by my healthcare providers regardless of any real or perceived conflict with any medical power of attorney signed by me, whether prior to or subsequent to the date of this authorization. I recognize and intend that this will result in multiple persons having the authority to obtain my protected individually identifiable health information. This authorization is not intended to replace a medical power of attorney nor to grant any person the authority to make healthcare decisions, but merely to obtain information and explanations.

COPIES:

A copy or facsimile of this original authorization may be accepted and relied upon as though it was an original document.

DEFINITIONS:

The term "individually identifiable health information" includes but is not limited to the following: All healthcare information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of healthcare providers and insurers, whether past, present or future and any other medical information which is in any way related to my healthcare. In this authorization, the term also includes the term protected medical information as sometimes used in HIPAA. The term healthcare providers includes but is not limited to the following: Doctors (including but not limited to physicians, podiatrists, chiropractors, or osteopaths), psychiatrists, psychologists, dentists, therapists, nurses, hospitals, clinics, pharmacies, laboratories, ambulance services, assisted living facilities, residential care facilities, bed and board facilities, nursing homes, medical insurance companies or any other medical providers or affiliates. In this authorization, the term also includes the term covered entity as sometimes used in HIPAA.

X_____ _____

Patient's Signature Date

Two Witnesses

(Cannot be related or anyone listed on page 1)

_____ _____

Witness #1 Witness #2

OR

Notary Public

Signed this_____day of_____, 20___, at Gillespie County, Texas.

_____

Signature of Notary Public State of Texas County of Gillespie

This document was acknowledged before me on_____by

(Patient's name)_____