TO BE VALID: Only one Appointment per Person per Form

Appointment / Recognition of Authorized Representative

My name is: _____ .
My social security number is _____ . My current address is:

_____
Number and Street City State Zip

I hereby appoint:

_____
Full name of authorized representative

as my authorized representative for inspection and disclosure of my protected health care information (PHI).

Subject only to verification of her/his identity and to any other limitations in this document, my authorized representative has the authority to do all of the following:

(a) Request, review and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

(b) Execute on my behalf any documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

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 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and 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 to give, disclose and release to my authorized representative at her/his request, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include

Initials:

_____ _____ _____
Principal Witness Witness

all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted disease, mental illness and drug or alcohol abuse.

The authority given to my authorized representative shall supersede any prior agreement that I may have made with any person or entity to restrict access to or disclosure of my individually identifiable health information.

The authority given to my authorized representative has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to any person or entity having the duty pursuant to HIPAA not to release or disclose my PHI without my consent.

I execute this appointment and authorization in the full understanding that: 1) I may revoke it in writing at any time by submitting a cancellation of it to any person or entity having the duty pursuant to HIPAA not to release or disclose my PHI without my consent; 2) If I complete more than one of these forms each will be honored until I revoke one or more of these forms; 3) a revocation will not be effective retroactively for information exchanges that have already occurred; 4) disclosure of my PHI could occur by the person who has been authorized by me to receive this information; 5) any further disclosure by my authorized representative is not covered by HIPAA guidelines; 6) I have the right to refuse to sign this authorization form; 7) treatment, payment, enrollment and eligibility for benefits may not be conditioned on obtaining an authorization.

(All signatures must be made at the same time.)

SIGNATURE OF PRINCIPAL
(Person creating the Appointment / Recognition of Authorized Representative)

SIGNATURE DATE

(The signing of this document by the principal revokes all previous documents which purport to appoint or recognize an authorized representative for the inspection and disclosure of my protected health care information (PHI) pursuant to the Health Insurance Portability and Accountability Act of 1996)

Initials:

Principal Witness Witness

STATEMENT OF WITNESSES

I know the principal personally and I believe her/him to be of sound mind and at least 18 years of age. I believe that her/his execution of this Appointment/Recognition of Authorized Representative is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage or adoption and am not directly financially responsible for the principal's health care. I am not a health care provider who is serving the principal at this time, an employee of the health care provider, other than a chaplain or a social worker, or an employee, other than a chaplain or a social worker, of an inpatient health care facility in which the principal is a patient. I am not the principal's health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness No. 1:

_____

(Print) Name Date

_____

Address

_____

Signature

Witness No. 2:

_____

(Print) Name Date

_____

Address

_____

Signature

STATEMENT OF AUTHORIZED REPRESENTATIVE

I understand that _____ has designated me to be her/his authorized representative for the inspection and disclosure of her/his protected health care information (PHI) pursuant to the Health Insurance Portability and Accountability Act of 1996). _____ has discussed her/his desires regarding health care decisions with me.

_____

Signature of Authorized Representative

Initials:

_____ _____ _____

Principal Witness Witness