Authorization for Release of Protected Health Information

(Valid Authorization Under 45 CFR Chapter 164)

Statement of Intent: It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits use, disclosure or release of my health information (or, sometimes herein, "protected medical information"). I am signing this Authorization because it is crucial that my health care providers readily use, release or disclose my protected medical information to, or as directed by, that person or those persons designated in this Authorization to allow them to discuss with, and obtain advice from, others or to facilitate decisions regarding my health care when I otherwise may not be able to do so without regard to whether any health care provider has certified in writing that I am incompetent for purposes of HIPAA:

1. Appointment of Authorized Recipients

I, _____, an individual, hereby appoints the following person as Authorized Recipients for health care disclosure under the Standards for Privacy of Individually Identifiable Health Care Information (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"):

1.

2.

3.

2. Grant of Authority

Therefore, I authorize a health care provider (a "covered entity" as defined by HIPAA) to use, release and disclose my individually identifiable health information in accordance with and as authorized by 45 CFR Sec(s). 164.502(a)(1)(i) and (iv), 164.502(a)(2)(i), 164.524 and 164.528.

I specifically authorize:

a. All covered persons and entities as defined in HIPAA, including but not limited to 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 health care providers or affiliates;

b. to use, release and disclose any of my protected medical information, including but not limited to, reports and/or records concerning my medical and psychiatric history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my health care. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization for access to, disclosure and release of ANY protected medical information by or to the persons named in this Authorization as if each person were me;

c. to, or as requested by, an Authorized Recipient;

d. to the Trustee or Successor Trustee of any trust of which I am a beneficiary or a trustee for the specific purpose of determining my capacity as defined in the trust agreement;

3. Termination

This Authorization is not affected by, and shall not terminate by reason of, my subsequent disability or incapacity. This Authorization shall terminate 2 years following my death or upon my written revocation expressly referring to this Authorization and the date it is actually received by the covered entity. 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. Such 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 it.

4. Re-disclosure

By signing this Authorization, I acknowledge that the information used, disclosed or released pursuant to this Authorization may be subject to re-disclosure by an Authorized Recipient whose names are written in paragraph 1 of this Authorization and the information once disclosed will no longer be protected by the rules created in HIPAA. No covered entity shall require an Authorized Recipient to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this Authorization.

5. Instructions to the Authorized Recipients

An Authorized Recipient shall have the right to bring a legal action in any applicable forum against any covered entity that refuses to recognize and accept this Authorization for the purposes that I have expressed. Additionally, an Authorized Recipient is authorized to sign any

documents that the Authorized Recipient deems appropriate to obtain use, disclosure or release of the protected medical information.

6. Effect of Duplicate Originals or Copies

If this Authorization has been executed in multiple counterparts, each counterpart original will have equal force and effect. An Authorized Recipient may make photocopies (photocopies shall include: facsimiles and digital or other reproductions, hereafter referred to collectively as "photocopy") of this Authorization and each photocopy will have the same force and effect as the original.

7. My Waiver and Release

With regard to information disclosed pursuant to this Authorization, I waive any right of privacy that I may have under the authority of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), any amendment or successor to that Act, or any similar state or federal act, rule or regulation. In addition, I hereby release any covered entity that acts in reliance on this Authorization from any liability that may accrue from the use or disclosure of my protected medical information in reliance upon this Authorization and for any actions taken by an Authorized Recipient.

8. Severability

I intend that this authorization conform to United States and Florida law. In the event that any provision of this document is invalid, the remaining provisions shall nonetheless remain in full force and effect.

I understand that I have the right to receive a copy of this authorization. I also understand that I have the right to revoke this authorization and that any revocation of this authorization must be in writing.

Dated: _____ _____

_____, Principal

STATE OF FLORIDA
COUNTY OF _____

The foregoing instrument was acknowledged before me this day _____, 20____, by_____ who [ ] is personally known to me or who [ ] has produced _____, as identification.

_____
Notary Public

My commission expires: