HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, **[CLIENT COMPLETE NAME]**, *[also known as _____,] authorize all "**Covered Entities**" (as defined in 45 C.F.R. Part 160, promulgated under the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**")) including, without limitation, physicians, nurses and all other persons who may have provided, or be providing, me with any type of health care, to disclose, orally or in writing, my "**Protected Health Information**" (as defined in 45 C.F.R. Part 160) that relates directly or indirectly to my capacity to act rationally and prudently in my own best interests and to manage my financial affairs:

(1) To any named agent or successor agent under any health care agency signed by me including, without limitation, that certain **Durable Power of Attorney for Health Care** executed by me *[of even date herewith] *[on _____], for the purpose of determining whether I can make or communicate my own medical decisions;

(2) To any named agent or attorney-in-fact or successor agent or attorney-in-fact under a durable general power of attorney signed by me including, without limitation, that certain **Financial Power of Attorney** executed by me *[of even date herewith] *[on _____], for the purpose of determining whether I am physically or mentally unable properly to manage my affairs, as defined in the power of attorney or by governing law;

(3) *[To the committee or any named member of committee charged with the responsibility of determining whether I am capable of managing my own affairs as set forth in my said Financial Power of Attorney.]

This authorization is intended to provide my Covered Entities with the authorization necessary to allow each of them to disclose protected health information regarding me to the persons described in *[(1)-(3)] above for the purpose of allowing each of them to make the specified determinations regarding my capacity or need for protective proceedings.

Information disclosed by a Covered Entity pursuant to this authorization is subject to redisclosure and may no longer be protected by the privacy rules of 45 CFR §164.

This authorization may be revoked by a writing signed by me or by my personal representative (as defined for purposes of HIPAA), except to the extent that action already has been taken in reliance on this authorization.

This authorization shall expire upon my death unless validly revoked prior to that date.

IN WITNESS WHEREOF, I have signed this instrument this _____ day of _____ 20___.

_____ _____(SEAL)
Witness Print Name: _____ **[CLIENT COMPLETE NAME]**
***[SSN: _____; DOB: _____]**

_____
Notary Public [Notary Seal]