

**SEPARATE HIPAA RELEASE AUTHORITY**

I intend for my surrogate to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d and 45 CFR 160-164.

Accordingly, I hereby authorize any doctor, physician, medical specialist, psychiatrist, chiropractor, health-care professional, dentist, optometrist, health plan, hospital, hospice, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, pathologist, or other provider of medical or mental health care, as well as any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has paid for or is seeking payment from me for such services, to give, disclose and release to my surrogate who is named in the attached Designation of Health Care Surrogate and who is currently serving as such, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. Such information may also be released to any person designated as a primary or successor agent or attorney-in-fact in a durable power of attorney which I have executed, whether or not such person is presently serving as such, and to any person presently serving as trustee or named as a successor trustee in any revocable or irrevocable trust created by me as grantor.

In determining whether I am incapacitated, all individually identifiable health information and medical records may be released to the person who is nominated as my surrogate in the **attached Designation of Health Care Surrogate**, including any written opinion relating to my incapacity that the person nominated as my surrogate may have requested. This release authority applies to any information governed by HIPAA and applies even if that person has not yet begun serving as my surrogate.

This authority given to my surrogate in the attached Designation of Health Care Surrogate shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to my surrogate in the attached Designation of Health Care Surrogate may be subject to redisclosure by my surrogate and may no longer be protected by HIPAA. The authority given to my surrogate in the attached Designation of Health Care Surrogate has no expiration date and shall expire only in the event that I revoke the Designation of Health Care Surrogate in writing and deliver it to my health-care provider. There are no exceptions to my right to revoke the Designation of Health Care Surrogate.

Date: \_\_\_\_\_

Print Name \_\_\_\_\_