PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION (HIPAA RELEASE)

I am_____, of_____
_____, with date of birth _____
_____. This is my Authorization for Disclosure of Protected Health Information.

Authorized Recipients of Disclosures

Name: _____
Address: _____
Phone: _____

Name: _____
Address: _____
Phone: _____

Name: _____
Address: _____
Phone: _____

Name: _____
Address: _____
Phone: _____

Persons Authorized to Make Disclosures

This Authorization applies to—and authorizes disclosures by—all of the following "Health Care Providers": (i) all doctors, nurses, therapists, hospitals, laboratories, clinics and other individuals or entities who ever provide me (or who have ever provided me) with any type of physical or mental health care; (ii) all insurance companies and administrators, and all other individuals or entities who may ever possess any of my protected health information; and (iii) all other "covered entities" as defined in the Health Insurance Portability and Accountability Act (HIPAA) and all relevant regulations.

Information That May Be Disclosed

This authorization applies to—and authorizes disclosures of—**ALL of my medical and health care information,** including all(i) Protected Health Information and Individually Identifiable Health Information, as defined by HIPAA; (ii) information relating to HIV or AIDS, drug or alcohol abuse, or mental or behavioral health, psychiatric care (other than notes); (iii)billing information; and (iv) other medical and health care information.

Additional Provisions

Purpose: I make this authorization because I want every Authorized Person to have unlimited access to all my medical and health care information at the request of the individual Authorized Person.

Voluntary: I make this Authorization by choice. I understand that I could refuse to make it without impacting my treatment or payment rights.

Scope: This Authorization is in addition to—and does not limit—any of my other estate planning documents, nor does it limit the right that any Personal Representative of mine (as defined in HIPAA) may have to any medical and health care information.

Revocation: This Authorization may be revoked by me or my personal representative at any time, but the revocation must be in writing and shall not apply to disclosures made before the revocation.

Termination: If not revoked, **this Authorization expires 4 years after my death.**

Re-Disclosure Risk: I understand that, once information is disclosed pursuant to this Authorization, it will no longer be covered by HIPAA's privacy rules and any of my Authorized Persons could re-disclose it without protection.

_____ Date_____
Name printed:_____

THE STATE OF TEXAS
COUNTY OF _____

SUBSCRIBED AND ACKNOWLEDGED before me by _____
_____ on this _____ day of _____,
20___.

_____
Notary Public, State of Texas

This authorization is intended to comply with the requirements of HIPAA. For policy of the U. S. Department of Health & Human Services regarding requirements as to specificity of description of medical records and providers in such authorizations, see http://www.hhs.gov/ocr/privacy/hipaa/faq/index.html .