**HIPAA AUTHORIZATION OF _____**

**1.1 HIPAA Authorization**

I, _____, of _____, the undersigned Principal, request and authorize all my Health Providers to disclose and release all of my Health Information to _____ (my "Authorized Recipient") that he/she may request from time to time. If _____ is unable to serve for any reason, I appoint _____ to serve as my Authorized Recipient. This instrument constitutes HIPAA Authorization under the regulations.

"Health Providers" means health care providers, health care clearinghouses, and health plans, and includes, but is not limited to, "Covered Entities" as defined in the HIPAA regulations.

"Health Information" means medical and billing information, and includes, but is not limited to, my entire medical record, mental health information, HIV-related information, genetic information, and all "Protected Health Information" as defined in the HIPAA regulations but excludes psychotherapy notes as defined in the HIPAA regulations.

I may revoke this HIPAA Authorization at any time, except to the extent that my Health Providers have already taken action based upon this HIPAA Authorization. I will revoke this HIPAA Authorization with respect to a Health Provider by delivering a written, signed revocation to the Privacy Officer of the Health Provider, and with respect to my Authorized Recipient by delivering a written, signed revocation to my Authorized Recipient.

This HIPAA Authorization is effective immediately and remains in effect until the later of 10 years after the execution of this HIPAA Authorization or 3 years after the date of my death, unless sooner revoked by me.

I understand that information disclosed under this HIPAA Authorization may be redisclosed if my Authorized Recipient is not required by law to protect the privacy of the information, or if such information is no longer protected by HIPAA or other federal or state health information privacy statutes or regulations.

This instrument is not valid as a HIPAA Authorization when provided to a Covered Entity because the Covered Entity has conditioned my treatment, payment, enrollment in a health plan, or eligibility for benefits on the provision to the Covered Entity of this HIPAA Authorization.

**1.2 Multiple HIPAA Authorizations and/or Consents**

I may have multiple concurrent valid HIPAA Authorizations, and I may name more than one person as my Authorized Recipients, either in a single HIPAA Authorization or in multiple concurrent HIPAA Authorizations. If more than one person is at any time my Authorized Recipient, my Authorized Recipients are each entitled to the disclosure and release of Health Information as defined in the HIPAA Authorization in which they are designated as my Authorized Recipient. My Authorized Recipients need not coordinate, communicate, or agree with one another. They may act alone or jointly.

This HIPAA Authorization explicitly does not revoke or amend any existing HIPAA Authorization I may have previously executed.

Note to my Health Providers: In the event that I sign or have signed a HIPAA Consent or other HIPAA Authorization that is more restrictive than this HIPAA Authorization, then unless the more restrictive document constitutes a HIPAA Authorization that explicitly revokes or supersedes this HIPAA Authorization, this HIPAA Authorization constitutes a written communication pursuant to 45 CFR §164.506(e)(2)(ii) that the broader scope of this HIPAA Authorization shall govern, contravening the general rule of 45 CFR §164.506(e)(1).

**1.3 Statutory and Regulatory References**

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

"HIPAA regulations" means 45 CFR Parts 160 and 164, as may be amended from time to time. Specific references to regulation section numbers are to the regulations as amended on October 15, 2002, and effective on April 15, 2003.

This HIPAA Authorization was undertaken and executed solely on my initiative. This instrument is therefore intended to constitute a HIPAA Authorization under 45 CFR §164.508(b) and (c) only, and not an Authorization under 45 CFR §§164.508(d), (e), or (f), nor a Consent under 45 CFR §164.506.

**1.4 Reliance**

My Health Providers may conclusively rely on the representation of my Authorized Recipient that I am living, or that less than 3 years have elapsed since the date of my death, and that this HIPAA Authorization has not been revoked, unless the Health Provider has actual knowledge to the contrary. My Health Providers shall not be under any obligation to conduct an independent investigation into the veracity of such representations.

**1.5 Multiple Originals; Photocopies**

If this HIPAA Authorization has been executed in multiple originals, each such original shall have equal force and effect. My Health Care Agent under a valid Health Care Proxy or my Authorized Recipient is authorized to make photocopies of this instrument as frequently and in such quantity as either of them shall deem appropriate. Each photocopy shall have the same force and effect as any original.

**1.6 Severability**

If any provision of this HIPAA Authorization is or becomes invalid or unenforceable in any respect, the remaining provisions shall not in any way be affected or impaired.

**1.7 Plain Language**

I have consulted with legal counsel prior to executing this HIPAA Authorization. I have read this entire HIPAA Authorization and declare that I find the language and meaning to be plain and apparent on its face.

I willingly execute this HIPAA Authorization by signing below.

_____ Date: _____

Principal