[My Name]’S HIPAA RELEASE

I, [my name], authorize my [relationship] [name of person authorized] to work with me to help me understand, make, and communicate my own medical decisions.

I intend for [name of person authorized] to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. For this purpose, I authorize the disclosure of my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing) for all conditions (including but not limited to mental health, communicable diseases, and alcohol and drug abuse treatment).

This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164 XII, and to other applicable federal and state laws regarding my medical care and records.

Therefore, I authorize [name of person authorized] to provide, request, receive, and review medical information about me to and from my health care providers. I also give [name of person authorized] the right and authority to attend medical appointments with me and talk to my health care providers about me. I authorize my medical and health care providers to speak with [name of person authorized] and to provide [her/him/them] with any medical records and information necessary to support me to make my decisions.

My records may be disclosed verbally, in hard copy, by electronic record, or by granting access though an online portal.

This authorization shall be effective unless I revoke it. I may revoke this authorization at any time by notifying my health care providers, preferably in writing.

_____ _____

Signature Date

_____

Printed Name