AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(HIPAA AUTHORIZATION UNDER 45 C.F.R. § 164.508)

A. Statement of Intent

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), that there are federal regulations that interpret and implement that law, and that HIPAA limits disclosure of my "Individually Identifiable Health Information" to certain of my family and friends, regardless of my state of health. I am signing this authorization so my Health Care Providers can disclose my health care information to the persons listed below, and openly discuss that information with them.

B. Authorization

I, [client], hereby authorize my physicians, nurses, hospitals and other Health Care Providers to fully disclose my Individually Identifiable Health Information to any or all of the following authorized persons (my "Personal Representatives"):

Name: ____

Address: ____

____

Phone: ____

Name: ____

Address: ____

____

Phone: ____

Further, if I have executed and have not revoked a Medical Power of Attorney and/or a Durable Power of Attorney naming other agents to make health care decisions and/or business and personal decisions on my behalf, then said agents shall be deemed automatically added to the above list of persons to have access to my personal medical records.

The fact that I may have named more than one party to have access to my protected

medical records shall not be interpreted as requiring all of their joint consent or signatures. Each person I designated shall have the authority to act individually and without notice to any other designated person.

C. Authority to Discuss and Answer Questions

My Health Care Providers are expressly authorized to answer questions posed by the Personal Representatives listed above and openly discuss with them my condition, treatment, test results, prognosis, and all other information pertinent to my health care, even if I am fully competent to ask questions and discuss my medical condition. This document constitutes a full authorization to disclose any Individually Identifiable Health Information to the Personal Representatives named in this Authorization.

D. Waiver and Release

I hereby release any Health Care Provider who acts in reliance on this Authorization from any liability that may accrue from releasing my Individually Identifiable Health Information and for any actions taken by my Personal Representatives.

E. Termination

This Authorization is effective as of the date shown as the date of its signing and shall not be affected by my subsequent disability or incapacity. This authorization shall terminate on this first to occur of: (1) two years following my death or (2) upon my written revocation actually received by the Health Care Provider. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the Health Care Provider.

F. Re-disclosure

By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Personal Representatives named in this Authorization and no longer by protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I fully indemnify my Health Care Providers for all consequences which may occur as a result of their good faith reliance and compliance with this Authorization. No Health Care Provider shall require my Personal Representatives to indemnify the Health Care Provider or agree to perform any act in order for the Health Care Provider to comply with this Authorization.

G. Enforcement

My Personal Representatives shall have the right to bring a legal action in any applicable forums against any Health Care Provider who refuses to recognize and accept this Authorization. Additionally, my Personal Representatives are authorized to sign any documents that my Personal Representatives deem necessary or appropriate to obtain my Individually Identifiable Health Information.

H. Conflicts With Other Authorizations

This Authorization is in addition to other medical release authorizations I may have granted in the past or future; it does not replace them. This Authorization may be relied upon by my Health Care Providers regardless of any real or perceived conflict with any Medical Power of Attorney signed by me, whether prior to or subsequent to the date of this Authorization. I recognize and intend that this may result in multiple persons having the authority to obtain my protected Individually Identifiable Health Information. This Authorization is not intended to replace a Medical Power of Attorney, nor to grant any person the authority to make health care decisions, but merely to obtain information and explanations.

I. Copies

A copy or facsimile of this original Authorization may be accepted and relied upon as though it was an original document.

J. Definitions

1. Individually Identifiable Health Information

The term "Individually Identifiable Health Information" includes (but is not limited to) the following:

All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information, the identity of health care providers and insurers, whether past, present or future, and any other medical information which is in any way related to my health care. In this Authorization, the term also includes the term "Protected Medical Information" as sometimes used in HIPAA.

2. Health Care Providers

The term "Health Care Providers" includes (but is not limited to) the following:

Doctors (including, but not limited to, physicians, podiatrists, chiropractors, or osteopaths), psychiatrists, psychologists, dentists, therapists, nurses, hospitals, clinics,

pharmacies, laboratories, ambulance services, assisted living facilities, residential care facilities, bed and board facilities, nursing homes, medical insurance companies, and any other medical providers or affiliates. In this Authorization, the term also includes the term "Covered Entity" as sometimes used in HIPAA.

Signed this _________ day of _______________, 200__.

____
[client]

State of Texas

County of ______________________

This document was acknowledged before me on [date] by [client].

____
(signature of notarial officer)

(Seal, if any, of notary)

____
(printed name)

My commission expires: ________________________