HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____, 20____

I. **THE PATIENT**. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____
Date of Birth: _____, 20____
Social Security Number: _____-____-_____

II. **AUTHORIZATION**. I authorize _____ ("Authorized Party") to use or disclose the following: (check one)

☐ - All of my medical-related information.
☐ - My medical information ONLY related to: _____.
☐ - My medical-related information from _____, 20____ to _____, 20____.
☐ - Other: _____.

Hereinafter known as the "Medical Records."

III. **DISCLOSURE**. The Authorized Party has my authorization to disclose Medical Records to: (check one)

☐ - Any party that is approved by the Authorized Party.
☐ - ONLY the following party:
Name: _____
Address: _____
Phone: (____) ____-_____ Fax: (____) ____-_____
E-Mail: _____

IV. **PURPOSE**. The reason for this authorization is: (check one)

☐ - **General Purpose**. At my request (general).

☐ - **To Receive Payment**. To allow the Authorized Party to communicate with me for marketing purposes when they receive payment from a third party.

☐ - **To Sell Medical Records**. To allow the Authorized Party to sell my Medical Records. I understand that the Authorized Party will receive compensation for the disclosure of my Medical Records and will stop any future sales if I revoke this authorization.

☐ - **Other**: _____.

V. TERMINATION. This authorization will terminate: (check one)

☐ - Upon sending a written revocation to the Authorization Party.
☐ - On the following date: _____, 20____.
☐ - Other: _____.

VI. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

Print Name: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

☐ - **Being a Minor**. Patient is ____ years old and considered a minor under state law.

☐ - **Being Incapacitated**. Patient is incapacitated due to: _____.

☐ - **Other**: _____.

Signature of Representative: _____ Date: _____

Print Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____.

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

I. **SENSITIVE INFORMATION**. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

(check one)

☐ - **I consent** to have the above information released.

☐ - **I do not consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____

II. **HIV/AIDS**. This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

(check one)

☐ - **I consent** to have the above information released.

☐ - **I do not consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____

MEDICAL POWER OF ATTORNEY

IMPORTANT INFORMATION

IT IS IMPORTANT THAT YOU REVIEW THE FOLLOWING INFORMATION BEFORE YOU SIGN THIS DOCUMENT. READ THE INFORMATION CAREFULLY AND SEEK GUIDANCE FROM A HEALTHCARE PROFESSIONAL OR ATTORNEY IF YOU DO NOT UNDERSTAND ANY OF THE TERMS.

By signing this document, you are giving authority to the person you are designating as your agent to make medical decisions on your behalf. Medical decisions can include any medical service, treatment, medical procedure, diagnosis or treat both mental and physical conditions. Your agent will be able to act with the same authority you would have if you were able to act for yourself and will have the authority to consent, refuse to consent to medical treatment including decisions about withdrawing or withholding life-sustaining treatment. It is, therefore, important that you know and trust your agent and that your agent is aware of your preferences for health care treatment.

Even after you sign this document, you will still be able to make your health care decisions assuming you are still considered mentally competent. Your agent cannot act on your behalf until your physician has determined that you are no longer physically or mentally able to make medical decisions.

The person you choose as your agent must be at least eighteen years old and someone that you trust with your health care. Your agent is not liable for any decisions they make on your behalf, as long as those decisions were made in good faith. You should make sure that you have chosen agent wants to take on the role as agent. Discuss your medical preferences with your agent so they are aware of your wishes. Review this document with your agent so they are aware of their role. You also may choose a back-up agent in case your other agent is unavailable to act. Your back-up agent should also be over 18 and aware of your preferences.

You may revoke this document at any time while you are still competent to do so. You may revoke it by telling your medical provider and your agent that you are revoking the document or you may provide them a written revocation. If you execute another power of attorney later, that will have the effect of revoking this one.

In order for this document to be valid, it must be signed in the presence of a notary or two witnesses. If you choose to have two witnesses sign, they must be at least 18, competent and independent and not your agent or related to your agent.

MEDICAL POWER OF ATTORNEY

I. APPOINTMENT OF HEALTH CARE AGENT

Principal: I, _____, with a mailing address of _____, LEGALLY APPOINT

Agent: _____, with a mailing address of _____, as my Agent to make medical decisions on my behalf, except to the extent I limit those decisions in this document. This power of attorney takes effect with my signature and when my doctor certifies in writing that I can no longer make health care decisions.

The Agent can be reached at the following contact details:

- Phone: _____
- E-Mail: _____

II. LIMITATIONS ON MY AGENT

My agent is authorized to make all medical decisions on my behalf **EXCEPT**:

III. APPOINTMENT OF ALTERNATE AGENT

If my agent appointed above is unable or unwilling to serve as my agent, I appoint the following person(s) to serve as agents in the order set forth below with the authority to make health care decisions on my behalf as provided herein:

A. First Alternate Agent

Name: _____
Address: _____
Phone: _____

B. Second Alternate Agent

Name: _____
Address: _____
Phone: _____

IV. ORIGINAL AND COPIES OF THIS DOCUMENT

The original document is/will be filed at the following location(s):

I have/will provide copies of my medical power of attorney to the following:

V. DURATION

Unless stated otherwise herein, this document shall remain in effect until I revoke it. I understand that I cannot revoke this document during the time I am considered incompetent to make my own decisions.

This power of attorney shall continue: (check one)

☐ - **IN PERPETUITY**. This power of attorney shall expire upon my death or written revocation.

☐ - **END DATE**. This power of attorney shall expire on _____, 20____.

VI. PRIOR MEDICAL POWER OF ATTORNEY

By signing this document, I hereby revoke any and all prior medical powers of attorney that I may have executed.

VII. LEGAL REQUIREMENTS (STATE LAW)

YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A **NOTARY PUBLIC**:

AND / OR

SIGN IN THE PRESENCE OF **TWO COMPETENT ADULT WITNESSES** NOT RELATED BY BLOOD OR MARRIAGE.

VIII. EXECUTION

Principal's Signature: _____
Print Name: _____ Date: _____

NOTARY ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of: _____}
County of: _____}

On this ____ day of _____, 20____, before me appeared _____, as Principal of this Medical Power of Attorney who proved to me through government issued photo identification to be the above-named person, in my presence executed foregoing instrument and acknowledged that (s)he executed the same as his/her free act and deed.

Notary Public: _____
Print Name: _____
My commission expires: _____

WITNESS STATEMENT AND ACKNOWLEDGMENT:

I am not the person appointed as agent or successor agent in this medical power of attorney. I am not related to the principal of this document by blood or marriage. I am not entitled to any portion of the principal's estate, nor do I have any claim against the principal's estate. I am not the attending physician of the principal or an employee of the attending physician. I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

SIGNATURE OF FIRST WITNESS:

1st Witness Signature: _____
Print Name: _____ Date: _____
Address: _____

SIGNATURE OF SECOND WITNESS:

2nd Witness Signature: _____
Print Name: _____ Date: _____
Address: _____