HIPAA Authorization

My name is _____. I reside at _____. Despite the provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), I want my healthcare providers to provide any and all of my protected medical information which any of the following named designated representatives may request to the designated representative making the request. Therefore, I am making this authorization pursuant to HIPAA and the regulations promulgated under HIPAA, including 45 CFR 164.501 and 45 CFR Sec. 164.508.

1. In this authorization:

1.1. A "covered entity" shall mean any health care provider as defined by HIPAA, including but not limited to a doctor (including but not limited to a physician, podiatrist, chiropractor, or osteopath), psychiatrist, psychologist, dentist, therapist, nurse, hospital, clinic, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate.

1.2. "Health information" means any and all information described in or protected by HIPAA, including but not limited to any and all health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my health care.

1.3. A "designated representative" shall mean a person named in Paragraph 4 below.

2. I authorize and direct each covered entity to disclose to any one or more of the designated representatives any and all health information he or she may request.

3. I also authorize and direct each covered entity, together with its employees and other agents, to discuss my health information with one or more of the designated representatives and to answer questions about my health information which any of the designated representatives may ask, whether or not I am incapacitated at the time.

4. My designated representatives are:

Name: _____

Address: _____

Phone: _____

Name: _____

Address: _____

Phone: _____

5. Each designated representative shall have co-equal authority to request and receive health information and is not required to act jointly with the other designated representatives, if any.

6. By signing this authorization, I acknowledge that the health information used or disclosed pursuant to this authorization may be subject to re-disclosure by one or more of the designated representatives, and the health information once disclosed will no longer be protected by HIPAA or the rules promulgated under HIPAA. No covered entity shall require any designated representative to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this authorization.

7. I release any covered entity that acts in reliance on this authorization from any liability that may accrue from releasing any of my health information and for any actions taken by one or more of the designated representatives.

8. Each designated representative is authorized to bring legal action in any appropriate forum against any covered entity that refuses to recognize and accept this authorization. Additionally, each designated representative is authorized to sign any documents that he or she deems appropriate to obtain the health information.

9. This authorization shall terminate on the first to occur of: (1) two years following my death or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. This revocation shall be effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has taken action in reliance on it. This authorization is not affected by my subsequent disability or incapacity.

10. A copy or facsimile of this original authorization shall be accepted as though it were an original document.

11. My refusal to sign this form will not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1).

12. I understand that I cannot be denied treatment based on a failure to sign this Authorization, and that a refusal to sign will not affect the payment, enrollment, or eligibility for any benefits.

13. I further understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signed _________________________, 20__

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Signature