HIPAA AUTHORIZATION

From: ____
Current Address: ____
Date of Birth: ____
SSN (Last 4 Digits): ____

This Authorization applies to any health information protected by the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and the regulations implementing it (45 C.F.R. §§160-164). It is intended to comply with all specific requirements of those regulations (45 C.F.R. §164.508(c)), as well as with the requirements of 42 C.F.R. Part 2 and the relevant privacy provisions of Ohio law.

I hereby authorize and direct all “covered entities” under HIPAA, and those entities’ “business associates,” as follows:

(1) **Information to be disclosed.** All of my protected health information and medical records regarding any past, present, or future medical or mental health condition, and including all information relating to the diagnoses and treatment of sexually transmitted disease, mental illness, and drug or alcohol abuse;

(2) **Persons who can request disclosure:**
(a) ____;
(b) Any individual named as my agent or alternate agent in my Durable General Power of Attorney;
(c) The Trustee or Successor Trustee of any trust of which I am a beneficiary, for the purpose of determining my capacity as defined in the Trust Agreement.

(3) **Persons to whom information may be disclosed.** Those persons identified in Paragraph (2) above.

(4) **Purpose of release.** The purpose of disclosure to persons named/identified in Paragraphs (2)(a) and (2)(b) is to enable those individuals to monitor and evaluate my health and my health care, to evaluate my financial circumstances and obligations, and to take such actions as are necessary to ensure my general well being. The purposes of disclosure to persons identified in Paragraph (2)(c) is as stated in that Paragraph.

(5) **Validity of copies.** A copy of this HIPAA Authorization shall have the same force and effect as the original.

(6) **Expiration.** This Authorization will continue until my death.

(7) **Revocation.** I may revoke or amend this Authorization at any time, except to the extent that action has already been taken in reliance upon it, by stating so in a

subsequently-dated writing that is delivered to the person(s) identified in Paragraph (3) above.

(8) **Information subject to re-disclosure.** I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure and may no longer be protected by HIPAA or other privacy laws.

______________________________________ ______________________________________

________________________________ Date