Authorization for Disclosure of Health Information
in accordance with the HIPAA Federal Privacy Regulations

PART ONE: PATIENT'S AUTHORIZATION

I, _____, hereby authorize my physician(s) and/or other health care providers, including any hospital or other health care facility in which I may receive care (each, a "Provider"), to disclose my individually identifiable health information as described in this form.

☐ SPOUSE: Any Provider may disclose and discuss with my spouse all relevant personal health information, including but not limited to any determination of whether I am capable of managing my financial affairs and whether I lack the capacity to make or communicate my treatment decisions.

☐ DURABLE FINANCIAL POWER OF ATTORNEY: Any Provider may disclose to and discuss with my primary agent or any successor agent acting under my Durable Financial Power of Attorney all relevant personal health information, including but not limited to any determination of whether I am capable of managing my financial affairs.

☐ DURABLE HEALTHCARE POWER OF ATTORNEY/PROXY: Any Provider may disclose to and discuss with my primary agent or any successor agent acting under my Durable Health Care Proxy all relevant personal health information, including but not limited to any determination of whether I lack sufficient capacity to make or communicate a choice regarding a health or personal care decision.

☐ LIVING WILL/ADVANCE DIRECTIVE: Any Provider may disclose and discuss with my primary agent or any successor agent, if any, acting under my Living Will/Advance Directive all relevant personal health information, including but not limited to any determination of whether I lack the capacity to make or communicate my treatment decisions.

☐ GUARDIAN: Any Provider may disclose and discuss with any court-appointed Guardian of my person all relevant personal health information, including but not limited to any determination of whether I lack the capacity to make or communicate my treatment decisions.

☐ TRUST OR OTHER AGREEMENT: Any Provider may disclose all relevant personal health information to the parties named as my successor Trustees in connection with the determination of whether I am competent to serve in a fiduciary capacity.

☐ Initials: _____ HIV/AIDS: If this box is checked and initialed, I specifically authorize the disclosure of information relating to acquired immunodeficiency syndrome (AIDS)/ human immunodeficiency virus (HIV) infection to the extent such information is relevant to the purpose of any disclosure as authorized above.

PERMITTED AND PROHIBITED DISCLOSURES

In addition to the authorizations set forth above, I wish to allow disclosure to the family members, friends, or individuals named below. Providers are authorized to discuss my health information and my health status with these individuals:

NAME	RELATIONSHIP	LIMITED* OR FULL DISCLOSURE?

* "Limited" disclosure means disclosure of information pertinent to my current condition or illness. "Full" disclosure means that a Provider may discuss any aspect of my health with this person.

Providers should NOT release any information to the following individuals unless otherwise specifically authorized by me:

NAME	RELATIONSHIP

I acknowledge and agree that the execution of this document will mean that Provider(s) will disclose to the persons or classes of persons named or described herein information regarding my mental status, capacity and/or competency.

EFFECTIVE DATE AND EXPIRATION: This Authorization is effective as of the date of its execution and will expire upon the first to occur of the following: (1) my death, or (2) my revocation of this Authorization.

PART TWO: ACKNOWLEDGEMENT AND NOTIFICATION OF MY RIGHTS AS A PATIENT

1. I understand that I have the right to revoke this Authorization at any time, except to the extent a Provider has already taken action in reliance on this Authorization. The revocation will not be effective until it has been received, in writing, by the Provider's privacy officer or other individual designated in the Provider's Notice of Privacy Practices.

2. I understand that a Provider may not condition my treatment, payment, enrollment, or eligibility for benefits on the signing of this form, unless the health care is solely for the purpose of creating health care information for disclosure to a third party. I understand and agree that this Authorization will be used to permit a Provider to disclose the results of a competency evaluation to the persons named or described herein, as applicable.

3. I understand that I may refuse to sign this Authorization. I acknowledge and agree that I am signing this document freely and without coercion so that other documents that I am a party to or acting as a fiduciary under can be implemented or administered in accordance with the terms thereof.

4. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by the Federal Privacy Standards.

5. I have retained a copy of this Authorization.

By signing below, I am indicating that I agree to release any and all Providers, their agents, officers, and other personnel from any legal responsibility or liability for disclosure of the above described information to the extent indicated and authorized herein, that I have read both pages of this Authorization and that I agree with its terms. A copy of this Authorization shall have the same force and effect as an original.

Signature of patient

Date

Printed name of patient