HIPAA/CMIA AUTHORIZATION
FOR RELEASE OF MEDICAL INFORMATION

I, _____, sometimes known as the "Patient," hereby authorize and direct any:

(1) physician, nurse, dentist, other healthcare professional, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider (including entities);
(2) insurance company; and
(3) the Medical Information Bureau, Inc. or any other health care clearinghouse,

that:

(a) has or is currently providing treatment or services to me; or
(b) has paid for or is seeking payment from me for such treatment or services,

to give, disclose, and release, without restriction, all of my protected health information regarding any past, present, or future medical or mental health conditions, including, if appropriate, information relating to the diagnosis and treatment of sexually transmitted diseases, mental illness, and/or drug or alcohol abuse, to my health care agent _____, who is sometimes referred to under California law as my "Patient's Representative" or under federal law as my "Personal Representative." If _____ shall be or become unable or unwilling to act as my Personal Representative, _____ shall become my Personal Representative, with all the powers accorded by this Authorization.

This authorization shall also serve as a "new authorization" under the California Confidentiality of Medical Information Act, California Civil Code § 56 *et seq*., as amended from time to time ("CMIA"), and the Health Insurance Portability and Accountability Act of 1996, 42 United States Code §§ 1320d *et seq*. and 45 Code of Federal Regulations Parts 160-64, as amended from time to time ("HIPAA"). Accordingly, my Personal Representative may further disclose the medical information received from any of the foregoing for my benefit without further authorization from me.

I am executing this Authorization for Release of Medical Information pursuant to the rights granted me by HIPAA and CMIA, it being my

intention that the medical information obtained by my Personal Representative be used for my (a) healthcare and well being, including, but not limited to, determination of my capacity to conduct my legal, financial and business affairs; (b) monitoring my health care to assure maximum access and use of (*i*) my health care rights and government benefits and (*ii*) my legal rights.

I voluntarily execute this Authorization understanding that I have a right to receive a copy of this Authorization and may, with limited exceptions, revoke this Authorization at any time by (a) destroying this Authorization or (b) delivering a written form of revocation to my named Personal Representative. The authority granted my Personal Representative by this Authorization shall supercede any prior agreement with my health care providers or prior Personal Representatives. The authority granted by this Authorization shall terminate upon the earlier of my death or its revocation as outlined in the first sentence of this paragraph.

Executed at _____, California, on _____, 20___.

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