PATIENT AUTHORIZATION

(Pursuant To HIPAA Regulations)

TO PERMIT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
By Any Hospital, Rehabilitation Center, or Care Giving Facility,
By Any Treating or Evaluating Physician, By Any Caregiver,
By My Personal Attorney, By the Personal Representative or Agent

Regarding: ____
Principal's name

Whose date of birth is ____________________

I am the person named above. By signing this form, I authorize any hospital, treating or evaluating physician, caregiver, care giving facility, or any other type of institution to discuss fully and freely any details of any issue applicable to me and to disclose any and all protected health information or any other information that the following people may ask for now and any time in the future unless I have revoked this authorization in writing and the person or institution with the information is aware of such revocation:

- ____;
  name relationship

- ____;
  name relationship

- ____;
  name relationship

- ____;
  name relationship

As well as

- My treating or evaluating physician;

- My caregiver, as identified by any of the above;
- Anyone else any person named above may authorize.

The purpose of the use or disclosure can be for any purpose any of them shall so deem and may be delivered in any way that is most convenient under the circumstances.

I understand that I may refuse to sign this Authorization. I also understand that the above-named entities cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization.

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by applicable federal medical privacy law and could be re-disclosed by the person or agency that receives it, however, I do not authorize such secondary disclosure, unless my family named above believes it is necessary for any reason.

This authorization expires only when I give the notice to my attorney, James L. Koewler Jr., who then will give notice to those institutions and persons as shall be necessary. My agent is authorized to make photocopies of this instrument as frequently and in such quantity as my agent shall deem appropriate. Each photocopy shall have the same force and effect as any original.

This Authorization is not affected by and shall not terminate by reason of my subsequent disability or death. This Authorization shall remain in effect until three years after my death. Any person named in this document shall have the right to bring legal action against any entity that refuses to recognize and accept this Authorization for the purposes that I have expressed. Additionally, any named agent is authorized to sign any document necessary to obtain use, disclosure, or release of any information.

I waive any right of privacy in regard to this Authorization. In addition, I hereby release any covered entity that acts in reliance of this Authorization from any liability that may accrue from the use or disclosure of released information requested by me or any agent as noted above.

I have read and understand the information in this authorization form.

Signature: ____ Date: ____________________

Prepared by:

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Form written by:
James L Koewler Jr
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With lots of help from (now retired)
attorney Michell Baumeister

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Jim does not seek payment for use but wants to have Michelle’s work and wisdom recognized.