HIPAA RELEASE

I intend for the person(s) named as my agent in the attached Health Care Power of Attorney to be my personal representative and therefore, be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health and mental health information or other medical records. This release and my agent's authority applies to any information governed by the Health Insurance Portability and Accounting Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164. I authorize any physician, health care professional, mental health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered healthcare provider, any insurance company and the Medical Information Bureau, Inc., or other healthcare clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition. The authority given my agent shall supercede any prior agreement that I may have made with my healthcare providers to restrict access to or disclosure of my individually indefinable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my healthcare provider.

I understand that this authorization is voluntary and that if the individual entity authorized to receive this information is not a covered entity under federal privacy regulations, the release of such information may no longer be protected by such regulations. I also understand that once this information is used or disclosed, it may be re-disclosed by the recipient.

_____ _____

Date of Release Signature

_____ _____

Date of Birth Print Name