

HIPAA COMPLIANT MEDICAL AUTHORIZATION
FOR DISCLOSURE OF HEALTH INFORMATION

TO ENSURE THIS FORM IS CONSISTENT WITH YOUR WISHES, PLEASE CONSULT AN ATTORNEY

To whom it may concern:

I, _____,
Name Address, City, State, Zip Code

hereby authorize the release of all medical documentation and other information, including protected health information that I could personally obtain upon request, which may be in the possession of any health care provider, medical care facility, insurer, physician, hospital, ambulance service or nurse or any other covered entity under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to

_____,
Name Address, City, State, Zip Code
_____,
Name Address, City, State, Zip Code
_____,
Name Address, City, State, Zip Code
_____,
Name Address, City, State, Zip Code

regarding my complete medical history and physical & mental condition both prior to and subsequent to the date of this authorization, regardless of lapsed time. The person(s) named above is/are hereby designated as my "personal representative(s)" as that term is used within HIPAA.

**I intend the person(s) listed above to have
authority to gain immediate access to my medical records.**

Upon presentation of this authorization (or a photocopy), you are authorized to release a copy of these records to any person who is my personal representative. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the personal representative and may no longer be protected by federal law.

The purpose of the disclosure is to enable the person(s) named above to fully act as my personal representative under HIPAA, including the ability to access and re-release my medical records. This authorization shall be deemed to comply with all requirements of HIPAA (45 CFR Section 164).

This authorization shall become effective on the date it is signed and expire two years after my death. I understand that I may revoke this authorization at any time, without regard to my mental or physical condition, by sending written notice to my medical providers or by using any method capable of revoking a health care agency under Illinois law.

Signature of person authorizing disclosure:

Witnessed on the
date noted above by:

Date

Signature of witness #1

Signature of witness #2

Print name of witness #1

Print name of witness #2

Witnesses should not be any of the persons listed above or heirs of mine.