HIPAA Release and Authorization

I, _____, residing at _____, with social security number _____, authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company, the Medical Information Bureau, Inc., and any medical information collection bureau or other health-care 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 the agent(s) as hereinafter described, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

The persons designated as my agents for purposes of this agreement are as follows:

- All person(s) designated as Patient Advocate, alternative Patient Advocate, health care agent(s) or alternative health care agent(s) in any Declaration for Medical Care or Power of Attorney for Health Care or similar document executed by me;
- All person(s) designated as my attorney-in-fact and/or Agent and their successors under any General Durable Power of Attorney or similar document executed by me;
- All person(s) designated as Trustee(s) and/or successor Trustee(s) under any Revocable Trust Agreement or living trust executed by me.

The authority given my agent(s) shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable 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 health-care provider.

I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d and 45 CFR 160-164, and all other applicable state and federal law.

IN WITNESS WHEREOF, I have signed and delivered this HIPAA Release and Authorization this _____ day of _____, 20____.

WITNESSES:

_____

_____ _____
Signature

STATE OF MICHIGAN)
) SS:
COUNTY OF)

On this _____ day of _____, 20____, before me, a Notary Public, personally appeared _____ who executed the above HIPAA Release and Authorization, and acknowledged the same to be his/her free act and deed.

_____
Notary Public, Acting in County, Michigan
My Commission Expires:

_____