CARRIER LAW

Health Insurance Portability and Accountability Act (HIPAA) Access, Authorization and Release Pursuant to 45 CFR 164.508

Appointment of Personal Representative

I, _____, currently residing at _____, acknowledge my privacy rights and understand that access to Protected Health Information about me must be obtained in accordance with the Health Insurance Portability and Accountability Act as implemented by the Rules and Regulations issued by the Department of Health and Human Services, especially as provided in 45 CFR 164.502, and as the Act and the Rules and Regulations may be amended from time to time ("HIPAA").

Appointment of Authorized Personal Representative

I grant my Personal Representative, _____, the power and authority to serve as my authorized Personal Representative for all purposes under HIPAA and is effective immediately. If my initial Personal Representative is unable or unwilling to act, then I appoint the following, in the order named, to act as successor Personal Representatives to serve with the same power: first, _____; second, _____; third, _____.

Access to Protected Health Information

I authorize my Personal Representatives to request, have access, and receive my protected health information from any health care provider, individual or organization covered by HIPAA. Upon request by my Personal Representatives, any health care provider, individual or organization subject to HIPAA shall disclose all requested protected health information pertaining to me, including, without limitation, all medical and mental health records, my diagnosis, prognosis, treatment, test results, opinions, clinical and non-clinical office notes and billings. This authorization is intended to comply with HIPAA and all other federal, state and local laws, regulations and codes related to privacy and the release of protected health information. This authorization shall be liberally construed to allow those named above to receive any and all requested protected health information concerning me. I understand that information used or disclosed pursuant to this authorization may be redisclosed by my authorized recipients, and therefore, may no longer be protected by HIPAA.

Authorizations and Releases

My Personal Representative may act for me and in my name and with the same authority I would have if personally present, for the purpose of signing (i) any Authorization required by HIPAA in order to obtain access to Protected Health Information about me and (ii) any other consent or release that might be required by any institution that has any document or other information covered by HIPAA.

Reproductions of this signed original (with a reproduced signature) shall be deemed to be an original counterpart of this authorization.

Important Privacy Rights Information

I understand the following:

- This authorization does not expire and shall be effective for past, present, and future periods, unless I revoke it. I may revoke this authorization in writing, at any time, by providing a copy of the written revocation to the Personal Representative. I understand that my revocation will not be valid to the extent that action was taken in reliance on this authorization. No entity or person acting in good faith and in reliance on this authorization, without actual knowledge of its revocation, shall incur any liability to me or my estate as a result of that action.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the Personal Representative of the information and may no longer be protected by federal privacy regulations.
- A covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization unless the health care provided is solely for the purpose of creating information for disclosure to my Personal Representative.

Date: _____ Date of birth: _____

Sign name: _____

Print name: _____

STATE OF MICHIGAN
_____ COUNTY

The foregoing Authorization and Release was subscribed and sworn to me by _____ on _____, 20_____.

Sign name: _____

Print name: _____

Notary Public, _____ County Michigan

Acting in _____ County

My Commission expires: _____