AUTHORIZATION UNDER HIPAA AND CMIA FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I, _____, hereby authorize, pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC §1320d and 45 CFR parts 160, 164, and the California Confidentiality of Medical Information Act (CMIA), Civil Code §§ 56 – 56.37, any covered entity, including, but not limited to, any physician, health care professional, dentist, health plan, hospital, nursing home, clinic, laboratory, pharmacy, any other covered health care provider, any insurance company, 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 to be paid for services, to give, disclose and release, without restriction, all of my individually identifiable health information and medical records governed by HIPAA and CMIA regarding any past, present or future medical or mental health condition, including, but not limited to, any and all information relating to the diagnosis and treatment of sexually transmitted diseases, mental illness (including information contained in mental health records protected by the Lanterman-Petris-Short Act), HIV/AIDS, and drug or alcohol abuse, to and upon request by one or more of the following individuals:

(a) An agent designated under an advance health care directive even if I have not been determined to lack capacity;

(b) An individual designated under a durable power of attorney signed by me as an individual responsible for determining my capacity when asked by the individual to do so for any purpose related to the individual's role under the durable power of attorney;

(c) An agent designated under a durable power of attorney signed by me when asked by the agent to do so for any purpose related to the agent's fiduciary capacity;

(d) An individual designated under a trust for which I am a settlor, trustee and/or beneficiary as an individual responsible for determining my capacity when asked by the individual to do so for any purpose related to the individual's role under the trust;

(e) The trustee, or a designated successor trustee, of any trust of which I am a settlor, trustee and/or beneficiary when asked by the trustee to do so for any purpose related to the trustee's fiduciary capacity;

(f) Any partner of any partnership of which I am a member when asked by the partner to do so for any purpose related to the partner's capacity as a partner in the partnership;

(g) A guardian ad litem, if one is appointed for me, when asked by the guardian ad litem to do so for any purpose related to the guardian ad litem's fiduciary capacity;

(h) A clergy member upon request specific to me for any purpose; and

(i) OTHER: [*fill in the name(s) of other individuals or indicate "None".*]

_____

2. I intend for the individuals named in the above paragraph to be dealt with by all my health care providers, as required by HIPAA and CMIA, in the exact same way as I would be treated with respect to my rights regarding the use and disclosure of my identifiable protected health information or other medical records.

3. I understand that:

(a) I may revoke this authorization at any time by written notice to the covered entity;

(b) The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign an authorization unless the law allows conditions; and

(c) I have a right to a copy of this authorization.

4. Although information disclosed by a health care provider pursuant to this authorization is subject to redisclosure and may no longer be protected by the privacy rules of HIPAA, California law prohibits the further disclosure of this information without a new authorization. It is my intention that this authorization form be construed to be a "new authorization that meets the requirements of Section 56.11" under California Civil Code Section 56.13 to permit further authorization by recipients of information initially received under this authorization.

5. This authority 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. This authorization shall expire two (2) years after my death unless validly revoked prior to that date.

Dated:_____ _____

Print:_____