

**GRANT OF AUTHORITY TO HEALTH CARE AGENT AND  
AUTHORIZATION UNDER HIPAA AND CALIFORNIA LAW FOR  
RELEASE OF HEALTH INFORMATION**

I, \_\_\_\_\_, grant to my agent \_\_\_\_\_, or any successor(s) nominated by him, under my advance health care directive the authority to advocate for my health care needs even if I have not been determined to lack capacity.

This release shall apply to any of my information which is governed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC §1320d and 45 CFR pts 160, 164, and California law. I intend my agent to be dealt with by all my health care providers, as required by HIPAA and California law, 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.

Pursuant to HIPAA and California law, I authorize any covered entity, including, but not limited to, any physician, health care professional, dentist, health plan, hospital, nursing home, clinic, laboratory, pharmacy, or any other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care 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 to my agent Lee Moss, without restriction and at the request of my agent and successor agent(s) that he designates, all of my individually identifiable health information and medical records 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.

I understand that:

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

This authorization shall expire on the date of my death unless validly revoked prior to that date.

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

I have a right to a copy of this authorization; and

Under California law, all recipients of protected health care information may not redisclose it except as required or permitted by law.

Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA regulations.

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. The authority given to my agent shall expire not expire, unless in the event that I revoke this authority in writing and deliver it to my health care provider.

Date: \_\_\_\_\_

Signature \_\_\_\_\_

