

Authorization for Release of Protected Health Information

(Valid Authorization Under 45 CFR Chapter 164 and § 146.82
through 146.83 and § 146.836 Wis. Stat.)

Statement of Intent: I understand that Congress passed a law entitled the Health Insurance Portability and Accountability Act (HIPAA) that limits use, disclosure, or release of my *individually identifiable health information*, as HIPAA and the supporting Regulations define that phrase. I am signing this authorization because it is crucial that my health care providers readily use, release, or disclose my protected medical information to, or as directed by, that person or those persons designated in this authorization. This authorization allows the designated persons to discuss with and obtain advice from others or to facilitate decisions regarding my health care when I otherwise may not be able to do so without regard to whether any health care provider has certified in writing that I am incompetent for purposes of HIPAA.

1. Appointment of Authorized Recipients

Therefore, I, _____, an individual, appoint the following persons or entities, or any of them, as Authorized Recipients for health care disclosure under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and § 146.82 through 146.83 and § 146.836 Wis. Stat.:

the Trustee or Successor Trustee of any trust of which I am a beneficiary or a trustee, for the sole specific purpose of determining my capacity as defined in the trust document; and

to my attorney for the limited purposes of determining my capacity to make gifts, to execute estate planning documents, to effectively manage my property and financial affairs, and to determine whether and to what extent a guardianship, conservatorship, or other protective proceeding for me is necessary or desirable.

2. Grant of Authority

I authorize all my HIPAA-defined covered entities to use, release, and disclose my individually identifiable health information to my Authorized Recipients under 45 CFR Sec(s). 164.502(a)(1)(i) and (iv), 164.502(a)(2)(i), 164.524 and 164.528, including medical reports and records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information, and identity of health care providers, whether past, present, or future, as well as any other information that is in any way related to my health care except as specifically limited as to any Authorized Recipient named in Paragraph 1 above.

This disclosure includes the authority to ask questions and discuss my individually identifiable health information with the person or entity that has possession of my individually identifiable health information even if I am fully competent to ask questions and discuss this matter at the time.

I intend to give a full authorization for access to, disclosure of, and release of ANY individually identifiable health information by or to the persons named in this authorization as if each person were me.

3. Covered Entity

Covered entity means any entity specifically defined by HIPAA or the supporting Regulations including any physician, podiatrist, chiropractor, osteopathic physician, health care professional, dentist, hospital, clinic, laboratory, pharmacy, ambulance service, assisted living facility, nursing home or 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 payment from me for such services.

4. Termination

My subsequent disability or incapacity will neither affect nor terminate this authorization. This authorization will terminate 2 years following my death or upon my written revocation expressly referring to this authorization and the date it is actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. This revocation is effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has taken action in reliance on it.

5. Redisdisclosure

By signing this authorization, I acknowledge that the information used, disclosed, or released under this authorization may be subject to redisclosure by an Authorized Recipient and the information once disclosed will no longer be protected under HIPAA. No covered entity may require an Authorized Recipient to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this authorization.

6. Instructions to the Authorized Recipient

An Authorized Recipient may bring a legal action in any applicable forum against any covered entity that refuses to recognize and accept this authorization for the purposes that I have expressed. Additionally, an Authorized Recipient is authorized to sign any documents that the Authorized Recipient considers appropriate to obtain use, disclosure, or release of my individually identifiable health information.

7. Effect of Duplicate Originals or Copies

If I have executed this authorization in multiple counterparts, each counterpart original will have equal force and effect. An Authorized Recipient may make photocopies (photocopies include facsimiles and digital or other reproductions referred to collectively as *photocopy*) of this authorization and each photocopy will have the same force and effect as the original.

8. My Waiver and Release

With regard to information disclosed under this authorization, I waive any right of privacy that I may have under the authority of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), any amendment or successor to that Act, or any similar state or federal act, rule, or regulation. In addition, I release any covered entity that acts in reliance on this authorization from any liability that may accrue from the use or disclosure of my individually identifiable health information in reliance upon this authorization and for any actions taken by an Authorized Recipient.

9. Severability

I intend to create an authorization that conforms to United States and Wisconsin law. In the event that any provision of this document is invalid, the remaining provisions remain in full force.

I understand that signing this authorization for disclosure is voluntary. A covered entity may not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits upon my signing of this authorization.

I understand that I have the right to receive a copy of this authorization. I also understand that I have the right to revoke this authorization and that any revocation of this authorization must be in writing.

Dated: April 30, 2024

STATE OF WISCONSIN

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) ss.

COUNTY OF OUTAGAMIE

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