MARQUETTE
NUTRITION & FITNESS, LLC

Authorization for Disclosure of Protected Health Information

My name is _____, and I reside at _____. This is my Authorization for Disclosure of Protected Health Information.

Authorized Disclosures

I hereby authorize all of my Health Care Providers to fully disclose all of my Protected Health Information (my "PHI") to any of the following (each an "Authorized Person"):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(name and address of recipient(s))

Persons Authorized to Make Disclosures

This Authorization applies to (and authorizes disclosures by) all of the following "Health Care Providers:" (i) all doctors, nurses, therapists, hospitals, laboratories, clinics, and other individuals or entities who ever provide me (or who have ever provided me) with any type of physical or mental health care; (ii) all insurance companies and administrators, and all other individuals or entities who may ever possess any of my protected health information, and (iii) all other covered entities as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") and all relevant regulations.

Information Which may be Disclosed

This Authorization applies to (and authorizes disclosures of) **ALL of my medical and health care information**, including: all (i) Protected Health Information and Individually Identifiable Health Information, as defined by HIPAA; (ii) information relating to HIV or AIDS, drug or alcohol abuse, or mental or behavioral health, psychiatric care (other than notes); (iii) billing information; and (iv) other medical and health care information.

Additional Provisions

Purpose: I make this Authorization because I want every Authorized Person to have unlimited access to all my medical and health care information.

Voluntary: I make this Authorization by choice; I understand that I could refuse to make it without impacting my treatment or payment rights.

Scope: This Authorization is in addition to, and does not limit, any of my other estate planning documents, nor does it limit the right that any Personal Representative of mine (as defined in HIPAA) may have to any medical and health care information.

Revocation: This Authorization may be revoked by me (or my personal representative) at any time, but the revocation must be in writing and shall not apply to disclosures made before the revocation.

Termination: If not revoked, this Authorization expires 2 years after my death.

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Authorization for Disclosure of Protected Health Information

Signed this _____ day of _____ 2____.

_____
(signature of patient)

_____
(name of patient)

_____
(signature of witness)

_____
(name of witness)