

# **Authorization for Release of S2 Test's Protected Health Information**

**(Valid Authorization Under 45 CFR Chapter 164 and California  
Civil Code Section 56)**

**Statement of Intent:** It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits use, disclosure or release of my health information (or, sometimes herein, "protected medical information"). 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 to allow them 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 California Probate Code Sections 4235, 4682 and 4690.

## **1. Appointment of Authorized Recipient:**

I, S2 Test, an individual, hereby appoint as my Authorized Recipient for health care disclosure under the Standards for Privacy of Individually Identifiable Health Care Information (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and as that term is defined by California Civil Code § 56.05(b) (referred to as my "Authorized Recipient")

## **2. Grant of Authority:**

Therefore, I authorize a health care provider (a "covered entity" as defined by HIPAA) to use, release and disclose my individually identifiable health information in accordance with and as authorized by 45 CFR Sec(s). 164.502(a)(1)(i) and (iv), 164.502(a)(2)(i), 164.524 and 164.528 and California Civil Code Section 56 Confidentiality of Medical Information Act (CMIA).

I specifically authorize all covered persons and entities as defined in HIPAA and CMIA, including but not limited to doctors (including but not limited to physicians, podiatrists, chiropractors, or osteopaths), psychiatrists, psychologists, dentists, therapists, nurses, hospitals, clinics, pharmacies, laboratories, ambulance services, assisted living facilities, residential care facilities, bed and board facilities, nursing homes, medical insurance companies or any other health care providers or affiliates, to use, release and disclose any of my protected medical information, including but not limited to, reports and/or records concerning my medical and psychiatric history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my health care. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization for access to, disclosure and release of ANY protected medical information by or to the persons named in this Authorization as if each person were me:

- a. to, or as requested by, Authorized Recipient;
- b. to the Trustee or Successor Trustee of any trust of which I am a beneficiary or a trustee for the specific purpose of determining my capacity as defined in the trust agreement;
- c. to my attorney, Richard Wingerden, for 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.

### **3. Termination:**

This Authorization is not affected by, and shall not terminate by reason of, my subsequent disability or incapacity. This Authorization shall 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. Such revocation shall be 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.

#### **4. Re-disclosure:**

By signing this Authorization, I acknowledge that the information used, disclosed or released pursuant to this Authorization may be subject to re-disclosure by the Authorized Recipient whose name is written in paragraph 1 of this Authorization and the information once disclosed will no longer be protected by the rules created in HIPAA and CMIA. No covered entity shall require my Authorized Recipient to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this Authorization.

#### **5. Instructions to my Authorized Recipient:**

My Authorized Recipient shall have the right to 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, my Authorized Recipient is authorized to sign any documents that the Authorized Recipient deem appropriate to obtain use, disclosure or release of the protected medical information.

#### **6. Valid Document:**

A copy or facsimile of this original Authorization shall be accepted as though it was an original document.

#### **7. My Waiver and Release:**

I hereby release any covered entity that acts in reliance on this Authorization from any liability that may accrue from the use, release or disclosure of my protected medical information in reliance upon this Authorization and for any actions taken by my Authorized Recipient.

**8. Severability:**

I intend that this Authorization conform to United States and California law. In the event that any provision of this document is invalid, the remaining provisions shall nonetheless remain in full force and effect.

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: \_\_\_\_\_

S2 Test, Principal

DOB: \_\_\_\_\_

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.
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State of California )  
County of \_\_\_\_\_)

On \_\_\_\_\_ before me, \_\_\_\_\_ (here insert name and title of the officer), personally appeared S2 Test, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature \_\_\_\_\_ (Seal)