HIPAA Privacy Authorization Form

Authorization for Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act 45 CFR Parts 160 and 164)

I, Vanessa Morgan, whose date of birth is 05/16/1965, authorize all medical service sources and health care providers and payers to disclose my protected health information (‘‘PHI’’) described below to:

Name: Isaac Morgan

Relationship: spouse

Contact Information: _____________________ Email: _____________________

I also authorize all health care providers to disclose my PHI to the trustee of any trust for which I am a Settlor, to my agent named in my general durable power of attorney, health care directive or health care power of attorney, and to my personal representative, executor, administrator, including any successor trustee, successor agent, or successor estate representative.

Health Information to be disclosed upon the request of the person named above (Check either A or B):

☑ A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR

☐ B. Disclose my health record, as above, BUT do not disclose the following (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify):

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☑ An electronic record or access through an online portal
- ☑ Hard copy

This authorization shall be effective: All past, present, and future periods

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____
Vanessa Morgan

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Date of signature