HIPAA AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION BY TRUSTOR, PRINCIPAL OR OTHERS

Pursuant to 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"), I _____, hereby authorize all health care providers and covered entities to disclose my protected health information (PHI) and medical information to Christopher A. Tancredo of The Tancredo Law Firm, P.A.

My attorney shall have the same access to Protected Health Information as I would. The authority granted to my attorney herein shall be effective immediately and shall not be dependent on a determination of whether or not I lack capacity.

I authorize the disclosure of all Protected Health Information, whether now existing or hereafter created, related to my physical and/or mental ability to (a) perform the duties of a trustee of a trust or administer a trust; (b) understand or be able to make or communicate decisions about my property or financial or business affairs or the property or financial or business affairs of any other person for whom I am an agent under a durable power of attorney; or (c) make informed health care decisions regarding myself or any other person for whom I am an agent under an advance health care directive or similar instrument.

This authorization shall apply to any physician or other health care provider who is providing health care services to me at the time such Protected Health Information is sought by my attorney.

Such Protected Health Information shall be provided to my attorney and any court or other governmental agency which may require such information in connection with any proceeding before such court or governmental agency. My attorney may disclose such Protected Health Information to such other persons or entities, such as trustees of trusts, which I am or have been a trustee or agent under durable powers of attorney or advance health directives executed by me.

This authorization shall remain in full force and effect until the earlier of (1) my written revocation hereof, or (2) my death. Any written revocation of the authorization shall be delivered to my attorney.

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 such revocation must be in writing.

Dated: _____ Signed: _____

[Individual's Name]