MEDICAL RECORDS RELEASE

I, _____, intend for any agent named in this release to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d and 45 C.F.R. 160-164.

I authorize the disclosure of any information governed by HIPAA to be provided to the following:

Accordingly, I hereby authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy 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, to give, disclose and release to any agent who is named herein and who is currently serving as such, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

This authority given to any named agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to any named agent may be subject to redisclosure by a named agent and may no longer be protected by HIPAA. The authority given to any named agent herein has no expiration date and shall expire only in the event that I revoke this HIPAA Release in writing and deliver it to my health-care provider. There are no exceptions to my right to revoke this HIPAA Release. I am signing this authorization voluntarily and any treatment, payment, enrollment or my eligibility for benefits will not be conditioned upon my authorization of this release.

_____

Signature

_____

Print Name Date

_____

D.O.B. S.S.N.