Rachel Lee Patient Advocacy Consulting, LLC.
Authorization for Release of
Protected Health Information
(HIPAA Authorization)

I, _____, hereby (i) designate Rachel Lee Patient Advocacy Consulting, LLC. and its directors, officers, employees, agents and authorized representatives (my Agent) to act as my designated Personal Representative, as that term is defined in the Health Insurance Portability and Accountability Act ("HIPAA"), and (ii) authorize (without any limitation whatsoever) anyone or any entity, whether or not associated with my healthcare (each of which shall be deemed a Covered Entity) to disclose to my Agent my individually identifiable health information (whether regarding my physical, mental or emotional health) and all health-related billing information.

My Identification Information:

Name: _____;

Date of Birth: _____.

Description of Information That May Be Disclosed. The Covered Entity is authorized and directed to disclose any and all information relating to my physical, mental and emotional healthcare, without limitation, even if it includes information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavior or mental health matters, or alcohol and/or other substance abuse to my Agent. There is no limitation on the information I authorize to be disclosed and there is no limitation on the period of time for which information may be requested or disclosed.

Person or Class of Persons to Whom the Covered Entity May Disclose the Above Described Protected Health Information. The Covered Entity shall disclose above-described information to my Agent. In the event my Agent is unable to serve or if my Agent is serving, I authorize my Agent to substitute another person for itself/herself/himself by designating such person as a successor Agent. Whenever the term Agent is used in this document, it shall apply equally to the Agent originally named and to all successors. My Agent shall be recognized as my designated Personal Representative (as that term is defined in HIPAA).

Purpose of Disclosure. Any purpose delineated by my Agent.

Termination. This Authorization shall terminate upon my written revocation actually received by the Covered Entity. Proof of receipt of my written revocation may be either 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 this Authorization.

Re-Disclosure. By signing this Authorization, I acknowledge that the information used or disclosed to my Agent pursuant to this Authorization may be re-disclosed by my Agent and the information once disclosed will no longer be protected by the rules created by HIPAA. No Covered Entity shall require my Agent to indemnify the Covered Entity or require my Agent to agree to perform any act in order for the Covered Entity to comply with this Authorization.

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Instructions to My Agent. My Agent shall have the right to bring a legal action in any applicable form against any Covered Entity that refuses to recognize and accept this Authorization for the purposes that I have expressed. Additionally, my Agent is authorized to sign any documents that my Agent deems appropriate to obtain any information of mine protected by HIPPA.

Revocation. I may revoke this Authorization in writing at any time.

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

My waiver and release. I hereby release any Covered Entity that acts in reliance on this Authorization from any liability that may accrue from releasing any information of mine protected by HIPPA to my Agent and from any actions taken by my Agent in re-disclosing or otherwise using any information of mine protected by HIPPA which the Covered Agent disclosed to my Agent. I also specifically prohibit my Agent or any other person designated as my Agent in any capacity from filing a complaint of any kind against any Covered Entity that complies with the directions of my Agent hereunder to the extent that such a complaint purports to charge said Covered Entity with any violation of HIPAA, any privacy rules or other federal or state laws related to disclosure of medical records as a result of their compliance with said directions.

Signed this _____ day of _____, 20_____.

Signature:_____

Print Name:_____

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