APPENDIX C

HIPAA Authorization to Allow Trustee's Doctor to Give Information to Facilitate Change of Trustee

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

This authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at 42 C.F.R. § 164.508.

All items on this authorization must be completed in full, or the request will not be honored.

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided treatment, payment or services to ROBERT A. WILLIAMS to release the protected health information of:

PATIENT: _____

DATE OF BIRTH: _____

PHONE #: _____

ADDRESS: _____

_____

The information is to be released to:

NAME: _____

ADDRESS: _____

_____

PHONE: _____

The information I wish to have released is (include dates of service):

My entire medical file

[New York–required information below]

I do __ I do not __ wish to have information about HIV/AIDS released under this authorization.

I do __ I do not __ wish to have information about drug/alcohol abuse treatment released under this authorization.

If the authorized releasor is in possession of records from another provider, I do __ I do not __ wish to have those records released under this authorization.

The purpose for such disclosure is:

___ At my request (only patient may check)

___ Payment/insurance

___ Health care ___ Employment

_ __Other: Trust administration; to determine suitability to continue as trustee

This authorization will expire:

I understand:

- ❑ This authorization is voluntary.
- ❑ My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this authorization form.
- ❑ I may receive a copy of this form.
- ❑ I may inspect my protected health information without signing this form.

- ❑ This authorization to disclose information may be revoked by me at any time except to the extent that action has been taken prior to receipt of revocation. To revoke this authorization, I understand that I must notify the releasor in writing.

- ❑ I understand that once information covered by this authorization has been disclosed, redisclosure of the information by that recipient is possible and the information may no longer be protected by the federal regulations referenced above but may be protected by state or other federal law.

Signature:

_____, _____, 2___
Robert A. Williams

If signature is by other than patient, explain your authority to act for the patient:

_____

_____

_____, _____, 2___
Witness