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Shelby Cnty Judge of Probate, AL
02/12/2010 01:56:36 PM FILED/CERT

Authorization to Disclose Protected Health Information

Name: Martha P. Cox

Address: 8500 Highway 51

City: Westover State: AL Zip Code: 35147

Telephone: [redacted] Email Address:

Appointment of HIPAA Personal Representatives

ALL of the persons, class of persons or entities designated below are authorized to receive my Protected Health Information:

- The Agent(s) and Successor Agent(s) appointed under my Advance Health Care Directive or Durable Power of Attorney for Health Care
- The Trustee(s) and Successor Trustee(s) appointed under my Revocable Living Trust or any other trust I have created during my lifetime.
- The Agent(s) and Successor Agent(s) appointed under my Durable Power of Attorney for Property
- The Law Firm of :

Jennifer Q. Griffin
Kendall Maddox & Associates, LLC
2550 Acton Road, Ste 210
Birmingham, Alabama 35243
(205) 977-9045
(205) 977-9049 facsimile

- The following named individuals:

Jannine C. Gore
Lorraine C. Fancher
Elaine C. Abston
David D. Cox

The person(s) or entity(ies) named above shall have the status, power, authority, rights and title as my Personal Representative(s) for all purposes as provided in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. L. 104-191, 45 CFR §§ 160–164.

I direct each health care provider or Covered Entity to release to my Personal Representative any and all Protected Health Information as may be requested and deemed necessary by my Personal Representative in order for my Personal Representative to perform his or her duties.

I authorize my Personal Representative to execute any and all releases and other documents necessary in order to obtain disclosure to my Personal Representative of my patient records and other Protected Health Information that may be subject to and protected under HIPAA.

I authorize my Personal Representative to appoint a Patient Advocate for me, who may be any person so designated by my Personal Representative. My Patient Advocate shall have the same right to ask questions and receive information regarding my medical condition(s), treatment, and any proposed treatment as I and my Personal Representative would have, and the right to be in attendance to me at all times.

I authorize my Personal Representative to take any and all legal steps to ensure compliance with my instructions to provide access to my Protected Health Information. Such steps shall include resorting to any and all legal procedures in an out of the courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorney fees against anyone who does not comply with this Authorization to Disclose Protected Health Information or my Advance Health Care Directive / Durable Power of Attorney for Health Care.

I understand that once my Protected Health Information is disclosed pursuant to this Authorization to Disclose Protected Health Information, it is possible that it will be no longer protected by applicable federal medical privacy regulations and could be re-disclosed by the person(s) or entity(ies) that receive it. I further understand that federal or state law may restrict re-disclosure of HIV / AIDS information, mental health information, and drug / alcohol abuse diagnosis, treatment, or referral information. Except as deemed necessary by my Personal Representative, I do not authorize such secondary disclosure of my Protected Health Information.

I understand that my Personal Representative may be receiving compensation for acting in the capacity designated above and may be compensated for obtaining my Protected Health Information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain medical treatment, or payment, or eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time. This Authorization to Disclose Protected Health Information shall expire one year after my date of death, unless it is revoked earlier.

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A photocopy or facsimile copy of this Authorization to Disclose Protected Health Information shall have the same effect as the original.

By signing below, I acknowledge I have read and understand this Authorization to Disclose Protected Health Information.

Date: 9/30/2009

Martha P. Cox
Signature of Patient or Patient's Legal Representative

If signed by the Patient's Legal Representative, describe the Legal Representative's authority.
☐ The Patient is a minor. I am the Patient's parent and natural guardian.
☐ The Patient is a minor. I am the Patient's guardian appointed by the _____ Court.
☐ The Patient is a ward. I am the Patient's guardian / conservator appointed by the _____ Court.
☐ I am the Patient's Agent appointed under the Patient's Advance Health Care Directive / Durable Power of Attorney for Health Care.
☐ The Patient is deceased. I am the Personal Representative of the Patient's estate, appointed by the _____ Court.

STATE OF ALABAMA)
SS
COUNTY OF JEFFERSON)

I, Jennifer Q. Griffin, a Notary Public in and for said County and State, hereby certify that MARTHA P. COX, Patient, whose name is signed to the foregoing conveyance or instrument and who is known to me, acknowledged before me on this day that, being informed of the contents of the instrument, he/she executed the same voluntarily on the day the same bears date.

Given under my hand on this 9/30/2009.

Jennifer Q. Griffin
Notary Public
My commission expires: 10/4/2010

This form is endorsed by the American Academy of Estate Planning Attorneys, and prepared by Jennifer Q. Griffin Attorney at Law.