

Designation of Health Care Surrogate

I, _____, a resident of _____ County, Florida,
hereby appoint the following persons, class of persons and entities as my HIPAA Personal
representatives, and I authorize such HIPAA Personal Representatives 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;
and/or

The Agent(s) and Successor Agent(s) appointed
under my Durable Power of Attorney
for Property.

The person(s) 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, and under any and
all state laws intended to provide privacy protection to me related to my medical, psychological,
psychiatric, health, drug or other such records and/or information (all such state laws shall be
hereinafter referred to as State-HIPAA laws).

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 and/or any State-HIPAA laws.

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 me Protected Health Information. Such steps shall include resorting to any and all legal procedures in and 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 the 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 and/or state medical privacy regulations and could be re-disclosed by the person(s) or entity(ties) that receive it. I further understand that federal or state law may restrict re-disclosure of HIV and/or 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.

Executed at _____ County, Florida, on _____, 2006

Type Name Here

1st Witness:

Signature: _____

Print Name: _____

2nd Witness:

Signature: _____

Print Name: _____

HIPAA AUTHORIZATION AND HIPAA HEALTH CARE POWER OF ATTORNEY

(Designation of Health Care Personal Representative)