HIPAA RELEASE AUTHORITY and WAIVER

I intend for my Health Care Agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1329d and 45 CFR 160-164.

Additionally, with full knowledge that said information may be disclosed further because it will no longer be subject to HIPAA regulations once disclosed, I hereby authorize and direct any physician, health care professional, psychologist, nurse, medical personnel, dentist, emergency medical technician, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, skilled nursing facility or assisted living facility and 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, or that holds or controls my medical records or information to give, disclose, and release upon oral or written request, any and all originals and copies (verbal, written, electronic, or the like), without restriction, of my medical records, medical information, clinical and other such notes (including diagnostic tests, x-rays, laboratory findings, etc, and [if allowed] psychiatric or psychological evaluations, and so forth) and to give orally all pertinent or requested said specific information concerning my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including without restriction all information relating to the diagnosis, prognosis, treatments and their side effects of any and all diseases affecting me or that have affected me including, without limitation, HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse to: **my Health Care Agent and Alternate Health Care Agent named herein and to the following individuals: Rev. Joseph M. O'Keefe, Jesuit Provincial and Jacqueline C. Perez, D.O. Health Care Coordinator for USA East, 39 East 83rd St., New York, N.Y. Tel.: 646-247-0374 and my local Jesuit rector or superior named below:**

{name, address, telephone numbers of local rector/superior}

The authority given to my Health Care Agent and the above-named individuals 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 authority given to my Health Care Agent and to the above-named individuals has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

I hereby grant my consent to the distribution of the above-stated information to the individuals so named, and I hereby sign my name to this Health Care Proxy, on this date, in the presence of the two witnesses named herein on page four.

Date: _____ _____

Signature of Principal