

**Authorization to Disclose Health Information to Persons  
Named as Health Care Agent and Attorney In Fact for Health Care Decisions**

I, \_\_\_\_\_ hereby authorize my attending physician to disclose to \_\_\_\_\_ and/or \_\_\_\_\_, whom I have appointed as my health care agent and/or attorney in fact for health care decisions (“my appointees”), protected health information regarding my ability to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment.

My appointees can only act as my health care agent and/or attorney in fact for health care decisions when I no longer have the ability to make informed health care decisions for myself as determined by my attending physician. In order for my appointees to exercise their responsibilities and powers as my health care agent and/or attorney in fact for health care decisions, they must be told by my attending physician whether I am able to make informed health care decisions for myself. The purpose of this authorization of disclosure is to allow my attending physician to give this protected health information to my appointees.

This authorization of disclosure of protect health information goes into effect upon my signing of this form, with no other conditions. This authorization will expire at such time as my attending physician has been provided my revocation of the named individual(s)’ appointment as my health care agent and/or attorney in fact for health care decisions or upon my death.

I authorize my appointees to re-disclose the protected health information described above as needed to fulfill their responsibilities under their appointments. I understand that this information, once disclosed, may be subject to re-disclosure by my appointees and no longer be protected by state or federal law.

I understand that I have the right to revoke this authorization, in writing, at any time by so notifying my attending physician. Such revocation will not affect actions taken by my physician prior to the date the written revocation was received.

I understand that my physician cannot condition medical treatment on whether I sign this authorization.

If requested by my appointees, I authorize and request that my attending physician provide a determination in writing of my ability to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment.

Date: \_\_\_\_\_

x \_\_\_\_\_