LINCOLN HILL MANOR

53 Lincoln Street Spencer MA 01562
(508) 885-3338

HIPAA Proxy

I, _____, residing at Lincoln Hill Manor Rest Home appoint as my HIPAA Personal Representative:

_____ _____
Representative Name *Representative Telephone*

_____
(Street) (City/Town) (State/ZIP)
Representative Address

Optional If my Representative is unwilling or unable to serve, then I appoint as my Alternate HIPAA Personal Representative with all the same powers:

_____ _____
Representative Name *Representative Telephone*

_____
(Street) (City/Town) (State/ZIP)
Representative Address

A. I appoint the above-named to serve as my Personal Representative (or Alternate), including any rabbi, priest, minister, imam, clergyman, or spiritual advisor, for any and all purposes of the Health Insurance Probability and Accountability Act of 1996 (HIPAA), and its regulations, together with such amendments as may, from time to time, be made.

B. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and any health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me or for such services, to give, disclose and release to my Personal Representative (or Alternate), without restriction, all HIPAA protected health information, included without limitation, past, present, or future medical and hospital records or communications for all of my individually identifiable health information, whether physical or mental, as well as all information relating to the diagnosis and treatment of HIV/AIDS/ARC, sexually transmitted disease, abortion, genetic testing, physical abuse, and substance abuse, including drug and alcohol abuse, mental retardation, developmental disability, mental illness, mental deficiency, and psychiatric illness.

C. I authorize my HIPAA Personal Representative (or Alternate) to request, receive, and review the above-mentioned information; to sign, seal, execute and deliver such authorizations, releases, or other documents as may be required; and generally, to do all acts and take all steps which in the judgment of my HIPAA Personal Representative (or Alternate) are necessary, convenient, or expedient. A copy of this HIPAA PROXY™ shall have the same force and effect as the original.

D. The authority given to my Personal Representative shall supersede any prior agreement that I may have made with my healthcare providers to restrict access to or disclosure of my individually identifiable health information.

E. The authority given to my Personal Representative 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.

Signed _____ Date _____/_____/_____

We, the undersigned, each witnessed the signing of this HIPAA Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the HIPAA Personal Representative (or Alternate) in this document.

In our presence, on this day _____/_____/_____.

Witness #1 _____
(Signature)
Name _____
(Print name)
Address_____
_____

Witness #2 _____
(Signature)
Name _____
(Print name)
Address_____
_____