trust&will

Instructions for Stacie Renee Clark HIPAA Authorization

Read & review

Make sure you understand it and ensure everything is correct.

Sign

Sign and date the document where indicated.

A notary is not required, but may be helpful. If you would like to have the document notarized, just sign the document while the notary watches.

Authorization to Release Medical Information for Stacie Renee Clark

I, Stacie Renee Clark, make this Authorization to Release Medical Information ("Authorization") to designate the individuals authorized to receive my Medical Information and to authorize my Health Care Providers to release my Medical Information to those designated individuals.

Designation of Personal Representative To Receive Medical Information

I designate the following individuals as my Personal Representatives and I authorize my Health Care Providers to disclose and release my Medical Information to any or all of my Personal Representatives:

- Clovis Clark ;
- Paytra R Gessler;
- Sophie R Gessler;
- The trustee or successor trustee of any trust for which I am a trustee or trustor;
- My personal representative, executor, administrator, or any individual serving the same or similar capacity in connection with my estate, including any successors; and
- Any agent or successor agent named under my health care directive or other medical or health care power of attorney.

It is my intention to provide the Personal Representatives named above broad rights to access and receive my Medical Information. Despite the provisions of HIPAA, I desire my Personal Representatives have access to my Medical Information, at the request of my Personal Representative. This Authorization constitutes a full authorization to disclose any Individually Identifiable Health Information to the Personal Representatives named in this Authorization.

I intend this Authorization to be broad and any questions or ambiguities regarding the provisions of this Authorization shall be resolved in favor of allowing the disclosure and release of my Medical Information to my Personal Representatives.

Definitions

The following definitions apply to this document:

- **Health Care Provider** refers to the term as defined by HIPAA and includes any person or entity that is subject to restrictions or limitations regarding confidentiality, privacy, and the release or disclosure of Medical Information. Health Care Provider includes medical doctors and physicians of any type; mental health providers including psychologists and psychiatrists; therapists; dentists; nurses; hospitals, clinics, and emergency care facilities; pharmacists and pharmacies; laboratories; emergency care providers, first responders, and ambulance services; nursing facilities and residential care facilities; medical insurance companies, or any other medical provider. Health Care Provider also includes any "Covered Entity" as used in HIPAA, any health care information clearinghouse, and any employees, officers, contractors, agents, or affiliates of any Health Care Provider.

- **HIPAA** refers to the Health Insurance Portability and Accountability of 1996 and relevant state law.

- **Individually Identifiable Health Information** refers to the term as defined by HIPAA and includes any "Protected Medical Information" as used in HIPAA; medical records of any past, present, or future medical or mental health condition; records, reports, or information regarding my medical history, diagnosis, prognosis, treatment, procedures, billing, and identification of my Health Care Providers; and any other information related in any way to my health care.

- **Medical Information** refers to any information related in any way to my health care, including Individually Identifiable Health Information and Protected Medical Information as defined in this Authorization, under HIPAA, and under relevant state law.

- **Personal Representative** refers to the term as defined by HIPAA and includes the individuals designated above and any personal representatives or authorized representative as used in relevant state law.

Additional Provisions

This Authorization is effective immediately upon my execution of this Authorization. This Authorization is durable and shall remain effective regardless of subsequent disability or incapacity. This Authorization shall terminate upon my written revocation received by my Health Care Provider or two years after my death, whichever occurs first.

This Authorization is in addition to and does not revoke or supersede any other authorizations I have granted in the past or may grant in the future. This Authorization does not replace any Advance Health Care Directive or medical power of attorney and any actual or perceived conflict with such documents does not affect the validity or scope of this Authorization. I reserve the right to revoke this Authorization in writing. Unless my Health Care Providers know of my revocation of this Authorization, my Health Care Providers may continue to rely on the validity and effectiveness of this Authorization.

I authorize and direct my Health Care Providers to provide information at the request of my Personal Representatives; answer questions asked by my Personal Representatives; and discuss my condition, treatment, test results, prognosis, and any other details of my health care, at the request of my Personal Representative.

I authorize my Health Care Providers to provide my Personal Representatives with a written statement, at the request of my Personal Representative, regarding:

1. my competency or incompetency to manage my financial and personal affairs, or

2. my diagnosis of being in an irreversible coma, in a persistent vegetative state with no reasonable possibility of returning to a cognitive life, or having incurable, irreversible, or terminal condition that is reasonably likely to result in my death within one year.

Any person authorized to receive my Medical Information may bring a legal action against any Health Care Provider that fails to accept this Authorization or refuses to provide my Medical Information for any purpose authorized by this Authorization.

I acknowledge that my Medical Information may not be protected by HIPAA after disclosure to my Personal Representatives and that my Medical Information may be re-disclosed by my Personal Representatives. I indemnify my Health Care Providers for any consequences of complying with this Authorization, including any consequences arising from the use of my Medical Information following an authorized disclosure and release to my Personal Representatives. No Health Care Provider may require any further indemnification by my Personal Representatives as a condition for the disclosure and release of my Medical Information. I release any Health Care Provider that relies on and acts in accordance with this Authorization in releasing and disclosing my Medical Information to my Personal Representatives.

I acknowledge that Health Care Providers may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility benefits upon the provision of this Authorization, except as provided under HIPAA.

Each of my Personal Representatives has equal authority to request and receive my Medical Information. Each of my Personal Representatives may act independently and without the consent of any other of my Personal Representatives.

My Personal Representatives are authorized and empowered to make one or more copies of this Authorization and provide such copies to my Health Care Providers. A copy of this Authorization has the same effect as the original.

Signature

I, Stacie Renee Clark, sign my name to this instrument and declare that I execute it as my free and voluntary act for the purposes expressed therein.

Stacie Renee Clark

4. 21. 1968

Date of birth:

Stacie R. Clark

Signature

11. 14. 2023

Date