NAME(S)	TELEPHONE NUMBER(S)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

F. IN CASE OF PREGNANCY
(OPTIONAL, FOR WOMEN OF CHILD–BEARING YEARS ONLY; FORM VALID IF LEFT BLANK)

IF I AM PREGNANT, MY AGENT SHALL FOLLOW THESE SPECIFIC INSTRUCTIONS:

_____
_____
_____

G. ACCESS TO MY HEALTH INFORMATION – FEDERAL PRIVACY LAW (HIPAA) AUTHORIZATION

1. IF, PRIOR TO THE TIME THE PERSON SELECTED AS MY AGENT HAS POWER TO ACT UNDER THIS DOCUMENT, MY DOCTOR WANTS TO DISCUSS WITH THAT PERSON MY CAPACITY TO MAKE MY OWN HEALTH CARE DECISIONS, I AUTHORIZE MY DOCTOR TO DISCLOSE PROTECTED HEALTH INFORMATION WHICH RELATES TO THAT ISSUE.

2. ONCE MY AGENT HAS FULL POWER TO ACT UNDER THIS DOCUMENT, MY AGENT MAY REQUEST, RECEIVE, AND REVIEW ANY INFORMATION, ORAL OR WRITTEN, REGARDING MY PHYSICAL OR MENTAL HEALTH, INCLUDING, BUT NOT LIMITED TO, MEDICAL AND HOSPITAL RECORDS AND OTHER PROTECTED HEALTH INFORMATION, AND CONSENT TO DISCLOSURE OF THIS INFORMATION.

3. FOR ALL PURPOSES RELATED TO THIS DOCUMENT, MY AGENT IS MY PERSONAL REPRESENTATIVE UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA). MY AGENT MAY SIGN, AS MY PERSONAL REPRESENTATIVE, ANY RELEASE FORMS OR OTHER HIPAA–RELATED MATERIALS.

H. EFFECTIVENESS OF THIS PART
(READ BOTH OF THESE STATEMENTS CAREFULLY. THEN, INITIAL ONE ONLY.)

MY AGENT'S POWER IS IN EFFECT:

1. IMMEDIATELY AFTER I SIGN THIS DOCUMENT, SUBJECT TO MY RIGHT TO MAKE ANY DECISION ABOUT MY HEALTH CARE IF I WANT AND AM ABLE TO.

_____

((OR))

2. WHENEVER I AM NOT ABLE TO MAKE INFORMED DECISIONS ABOUT MY HEALTH CARE, EITHER BECAUSE THE DOCTOR IN CHARGE OF MY CARE