

**THE HEALTH INSURANCE
PORTABILITY AND ACCOUNTABILITY ACT**

The Health Insurance Portability and Accountability Act ("HIPAA") regarding privacy of medical records may make it difficult for your successor trustee(s) and agent(s) to take over in the event of your incapacity. The Authorization to Physicians contains your instructions regarding the release of your medical information to your designated successor trustee(s) and agent(s). It is recommended that you give a copy of the Authorization of Physicians to your attending physician(s).

AUTHORIZATION TO PHYSICIANS

I, **JOHN A. GREEN**, being of sound mind in accordance with the Health Insurance Portability and Accountability Act ("HIPAA") willfully and voluntarily authorize my physician or any physician associated with my care to consider this instrument my express direction, disclosure and mandate to release any and all medical information, including but not limited to all Protected Health Information (as defined under HIPAA, to include all individually identifiable health information), including my past, present or future physical or mental health, or condition to **NANCY A. GREEN**. If **NANCY A. GREEN** is deceased, resigns, or is incapacitated, then to **LINDA B. GREEN**. If **LINDA B. GREEN** is deceased, resigns, or is incapacitated, then to **PAUL B. GREEN** (referred to individually as "my agent").

This authorization is made for the sole purpose of use in conjunction with my desire to provide for the proper management and disposition of my estate but shall in no way be construed as an authorization to release any Protected Health Information to any person other than my agent.

Any physician relying or acting upon this authorization shall be entitled to presume conclusively that this instrument was signed voluntarily and is in full force and effect unless written notice is given by me to such physician that this instrument has been revoked. Such physician is directed to treat my agent the same as he or she would treat me with respect to uses and disclosures of my protected health information as well as my rights under HIPAA. I further certify that I am aware of the potential for any information to be subject to re-disclosure by my agent and no longer protected by the Privacy rule.

If any physician with whom my agent seeks to consult on my behalf refuses to recognize my agent's authority pursuant to this authorization, I authorize my agent to sue and recover from such physician all resulting damages, costs, expenses and attorney's fees that are incurred because of such failure to act. The costs, expenses and attorney's fees incurred in bringing such action shall be charged against my general assets, to the extent that they are not recovered from said physician.

This authorization shall expire upon my death unless written notice is given that this instrument has been revoked at an earlier date.

Dated this _____.

JOHN A. GREEN

STATE OF ARIZONA)
) ss.
COUNTY OF PIMA)

On _____, before me, the undersigned, a Notary Public in and for said County and State, personally appeared **JOHN A. GREEN**, known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument, and acknowledged to me that he executed the same.

WITNESS my hand and official seal.

My Commission Expires:

Notary Public