REID AND RIEGE P.C.
COUNSELLORS AT LAW

Individual Clients Group Newsletter

Spring 2016

Health Care Emergencies and the College Student

Enclosed with this newsletter is a health care form you might want your child or grandchild to sign when he or she turns 18. At age 18, a child can make her or his own health care decisions. In addition, a parent no longer has automatic access to the child's private health information. This can prove problematic when the child is away at college and there is a health issue. Without proper authorization, a parent could not speak with doctors, review records or make decisions on behalf of the child.

The enclosed form can be used to name a HIPAA agent and health care representative. You can fill in the name of the representative (usually a parent or both parents, such as "my parents, Susan Smith and Joseph Smith, or either of them"). The child should sign before two disinterested witnesses, who should then sign to the left of the child's signature. We suggest that you make photocopies of the form and that the child sign several originals. This document is also available on our website at www.rrlawpc.com.

Children are also responsible for their own financial affairs at age 18. They may need a power of attorney, a Will or other estate planning documents. If so, we would be pleased to meet with your child.

The Reid and Riege Individual Clients Group Newsletter is a publication of Reid and Riege, P.C. The Newsletter is designed to provide clients and others with information on recent developments which may be of interest or helpful to them. Readers are urged not to act on this information without consultation with their counsel.

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HIPAA INFORMATION RELEASE AUTHORIZATION AND APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I, _____, of _____, Connecticut, declare this to be my HIPAA Release Authorization and Appointment of Health Care Representative. I appoint _____, as my HIPAA Agent and health care representative for the purposes described below.

HIPAA INFORMATION RELEASE AUTHORIZATION

I hereby authorize any doctor, hospital, laboratory, insurer, or any other person or entity in possession of my protected health information as such term is defined in 45 C.F.R. §164.501 ("Protected Health Information"), or any successor or related regulations or statutes, to disclose my Protected Health Information to my HIPAA Agent(s). In addition to the powers granted hereunder, my HIPAA Agent(s) shall have the power and authority to serve as my personal representative for all purposes under the federal Health Insurance Portability and Accountability Act of 1996, U.S. P.L. 104-191 ("HIPAA"), and in particular, its 2003 Privacy Regulations.

I authorize for disclosure, the following:

A. Protected Health Information in my medical file(s);
B. All other documents in my medical file other than Protected Health Information; and
C. All invoices and copies of all billing for services rendered.

Upon the request of a HIPAA Agent, I authorize disclosure of the information described above for my health care and planning, disability care and planning, support and/or maintenance care and planning, education planning, financial planning, and estate planning. I specifically grant my HIPAA Agent the power to request, review, and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records and any other health information protected under HIPAA.

This authorization is voluntary. I understand that it shall not be affected by my subsequent disability or incapacity. This authorization and release shall be effective immediately, and unless revoked in writing, shall continue in full force and effect and shall expire only on the date which is two (2) years after the date of my death.

I understand that a revocation is not effective to the extent that any person or entity who has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I further understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, I authorize my health care representative to make any and all health care decisions for me, including the decision to enter any health care facility; the decision to accept

or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, including, but not limited to, psychosurgery or shock therapy; and the decision to provide, withhold or withdraw life support systems. I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes. I grant my health care representative full and unqualified authority to delegate any or all of the foregoing powers to any person or persons whom my health care representative shall select.

Photocopies of this HIPAA Release Authorization and Appointment of Health Care Representative shall have the same force and effect as the original.

I have signed this Authorization and Appointment on _____.
Date

_____
Witness

_____
Print name:

_____
Witness