AUTHORIZATION FORM
FOR DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)
TO DESIGNATED PERSONAL REPRESENTATIVE(S)

I hereby authorize the use or disclosure of protected health information about me by the Company as described below. As used in this authorization, the Company shall mean BIFS, LLC, dba Baker Insurance and Financial Services, 1005 S Jackson, St., Jacksonville, TX 75766.

The purpose of this authorization is to allow the individual(s) listed below to act as my personal representative(s) in the disclosure, use or request of my protected health information. The Company may release my protected health information which is described below to the following person(s):

_____

Name Relationship Address City,State,Zip Phone

_____

Name Relationship Address City,State,Zip Phone

I grant to the individual named above access to (MUST CHECK ONE):

___ All of my PHI - I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse

___ Other: please specify limits or specific health care incident: _____

_____

I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to Baker Insurance at 1005 S Jackson St., Jacksonville, TX 75766.

I understand that this designation will (MUST CHECK ONE):

___ Be effective for my lifetime unless revoked

___ Expire two (2) years from the date the authorization is signed

I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I understand that I or my personal representative is entitled to receive a copy of this authorization upon request.

_____
Printed Name

_____ _____
Signature Date