EDWARD R. CASSEL

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")

HEALTH CARE AUTHORIZATION DOCUMENT

I hereby appoint my spouse, **Jeanne M. Cassel**, 5307 Robin Drive, Greendale, WI 53129, (414) 507-6927 (cell); my son, **Edward J. Cassel**, 1333 Madison Avenue, South Milwaukee, WI 53172, (414) 232-6273; my sister, **Barbara Gruenwald**, 3363 N. 45th Street, Milwaukee, WI 53216, (414) 442-4043; and my brother-in-law, **Robert J. Bahr**, 16001 N. 99th Drive, Sun City, AZ 85351, (602) 908-2247; as my personal representatives for all purposes of the Health Insurance Portability and Accountability Act of 1996, (Pub. L. 104-191), 45 CFR Section 160 through 164 ("HIPAA"). Except as otherwise stated herein, this appointment is effective immediately.

Each of my health care providers and any Covered Entity (as defined in HIPAA) in possession of any of my individually identifiable health care information is directed to release to my personal representatives and/or my Patient Advocate such medical information and financial information as may be requested by my personal representative. Accordingly, my personal representatives shall have access to any and all medical records, medical history, including mental health records, billing and all other information related to my medical care and mental health. All third parties, including the Veterans Administration, Medicaid and Medicare agencies, insurance companies, physicians, pharmacists, healthcare facilities and mental health facilities, assisted living facilities, community based residential facilities, nursing homes, clinics, hospitals and all other providers of my medical care shall comply with my personal representative's or Patient Advocate's request for information and accept any waivers, releases and revocations executed by my agent.

My personal representatives are authorized to waive all medical and financial privacy rights I may have. My personal representatives are also authorized to execute any and all releases and other documents necessary in order to obtain disclosure of my patient records and other medical information subject to and protected under HIPAA.

My personal representatives shall also be authorized to appoint a Patient Advocate for me, who may be one of my personal representatives or any other person or entity. My Patient Advocate shall have the same right to ask questions and receive information regarding my medical condition(s), treatment, and any proposed treatment as my personal representatives would have, and the right to be in attendance at all times.

The purpose of disclosures pursuant to this HIPAA authorization is to assist my personal representatives in making or assisting in making healthcare decisions for me and also for any other purpose my personal representatives determine to be in my best interest.

Copies, faxes, e-mails or other evidence of the authority and waiver granted herein may be relied upon as though an original was provided.

This authorization shall continue in full force and effect until my death.

I understand that I may inspect or copy the protected health information described by this authorization.

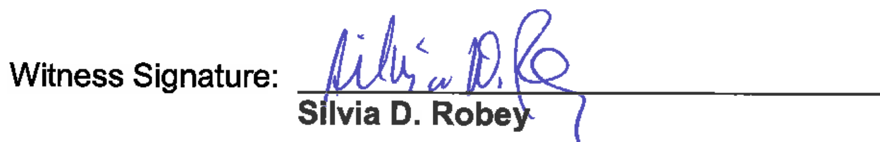
I understand that at any time this authorization may be revoked and that the revocation will be effective when the covered entity receiving this authorization receives a written notice of such revocation. I also understand that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for health care will not be affected if I refuse to sign this authorization.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may be subject to federal or state law protecting its confidentiality.

Dated this 13th day of October, 2017.

Principal Signature:
Edward R. Cassel

Witness Signature:
Sumeeta A. Krishnaney

Witness Signature: 
Silvia D. Robey

AUTHORIZATION TO DISCLOSE
HIPAA PROTECTED
HEALTH INFORMATION

1. **INDIVIDUAL AUTHORIZING DISCLOSURE.**

Name: **Edward R. Cassel** Date of Birth: 8/8/1940
Address: 5307 Robin Drive, Greendale, WI 53129
Telephone: (414) 507-6923 (cell)

2. **PSYCHOTHERAPY NOTES.** This authorization does not apply to psychotherapy notes.

3. **THE USE AND/OR DISCLOSURE BEING AUTHORIZED**. I hereby authorize each of my health care providers and health plans (as defined in HIPAA) to disclose any and all of my protected health information (as defined in HIPAA), including, but not limited to, a copy of any power of attorney documents executed by me, to the following persons for the purpose of permitting such persons to be involved in my health care and/or payment for my health care:

Jeanne M. Cassel **Barbara Gruenwald**

Edward J. Cassel **Robert J. Bahr**

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to: [check all that apply]

X Mental Health X Developmental Disabilities X Alcohol &/or Drug Abuse

X HIV test results X Other (specify): ALL

4. **PURPOSE**. The authorized disclosures are made at my request.

5. **EXPIRATION**. This authorization will expire upon my death.

6. **RIGHT TO REVOKE**. I understand that I have the right to revoke this authorization at any time by giving written notice of revocation to each person or organization to which I have provided a copy of this authorization. I further understand that revocation of this authorization will not affect any action taken in reliance of this authorization before written notice of revocation was received.

7. **NO CONDITIONS**. This authorization is voluntary. No covered entity has conditioned treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.

8. **EFFECT OF GRANTING THIS AUTHORIZATION**. I understand that information which is disclosed based on this authorization may be re-disclosed and no longer protected by Federal privacy laws.

I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am authorizing my health care providers and health plans to disclose my protected health information, as described in this form. I have been provided with a copy of this authorization. I understand that I have the right to inspect or copy the health information I have authorized to be disclosed by this form.

SIGNATURE: [signature] **DATE**: October 13, 2017
Edward R. Cassel