AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I authorize all health care providers, including physicians, nurses, and all other persons (including entities) who may have provided, or be providing, me with any type of health care, to disclose all of my protected health information:

   (a) to any of the following: ____

   ____

   (b) to the Archbishop of the Archdiocese of Galveston-Houston of the Roman Catholic Church or his representative.

   (c) to an agent designated under a medical power of attorney or durable power of attorney signed by me when asked by my agent to do so for the purpose of determining my capacity as defined in the power of attorney or by governing law,

   (d) to the trustee, or a designated successor trustee, of any trust of which I am a beneficiary or a trustee when asked to do so for the purpose of determining my capacity as defined in the trust,

   (e) to any business entity of which I am a member, director, officer or partner for the purpose of determining my capacity to continue in such capacity,

   (f) to any of my lawyer for the purposes of determining my capacity to make inter vivos gifts, to execute estate planning documents, and whether, and to what extent, a guardianship or other protective proceedings for me is necessary or desirable, and

   (g) to an attorney ad litem or a guardian ad litem, if one is appointed for me, for the purpose of determining whether and to what extent a guardianship or other protective proceedings for me is necessary or desirable.

2. This authorization is intended to provide my health care providers with the authorization necessary to allow each of them to disclose protected health information regarding me to the persons described in (a)-(g) above for the purpose of allowing each of them to make the specified determinations regarding my capacity or need for protective proceedings.

3. Information disclosed by a health care provider pursuant to this authorization is subject to re-disclosure and may no longer be protected by the privacy rules of 45 CFR ' 164.

4. This authorization may be revoked by a writing signed by me or by my personal representative.

5. This authorization shall expire 6 years after my death unless validly revoked prior to that date.

SIGNED on this the _____ day of ____________________________, year of Our Lord ________.

____(L.S.)
Declarant's Signature

____
Declarant's Printed Name