



**POWER OF ATTORNEY FOR MEDICAL SERVICES:
DELEGATION OF AUTHORITY**

TO ANY MEDICAL DOCTOR AND/OR MEDICAL FACILITY, OR TO WHOM IT MAY CONCERN:

The undersigned, _____ and _____,
the legal and physical custodians of the minor child(ren): _____

_____ hereby consent, authorize and fully empower _____ to do and perform any and all things, whatsoever, as is in his/her/their judgment necessary, relevant and required to obtain any and all medical attention and services, of any kind or nature, for and on behalf of the above named child(ren); and the same with full consent, authority, and power to sign any and all instruments, documents, and papers necessary in the name of the undersigned or otherwise, the same as the undersigned would or could do.

This instrument also authorizes any doctor, hospital, institution, clinic, firm, or medical facility of any kind, or agent thereof, to charge the undersigned for the services and supplies so rendered making the same a binding and legal debt of the undersigned, as though the undersigned had contracted therefore; nevertheless, utilizing any medical insurance carried by the undersigned on behalf of and covering the said child(ren).

The undersigned do hereby appoint said _____, as the true and lawful attorney(s)-in-fact of the undersigned with the full right, power, and authority in the name and stead of the undersigned, giving and granting unto said attorney-in-fact the full power and authority to do and perform all, each and every act, matter, and thing whatsoever requisite, necessary or proper to be done in the matters herein set forth, as fully, as the undersigned might or could do if personally present.

This Power-Of-Attorney shall be effective from 12:01 A.M. on _____, to, and shall expire at, midnight of _____.

AUTHORIZATION TO RELEASE INFORMATION:

The undersigned authorizes any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to the child(ren) or that has paid for or is seeking payment for the child(ren) for such services, to give, disclose, and release to the person or persons designated in this document to act as the agent such of the individual identifiable health information and medical records of my said child (ren) regarding any past, present or future medical or mental health condition

(including all specially protected health information relating to each of the following conditions specifically authorized by me to be disclosed by marking the box with an "X" or a check mark:

sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV);

behavioral and mental health;

alcohol, drug and other substance abuse; and

genetic-related information);

_____ Signature of Parent _____ Date

relating to the child(ren)s ability to make health care decisions. The purpose of this request is to assist in determining whether the person designated to act as the agent should act as the child(ren) agent. This authorization expires when I die or when revoked by me by a written revocation signed by me and delivered to the entity from which information is being requested prior to the time information is being requested.

I understand I can revoke this authorization by delivering a written statement of revocation to any entity I have authorized to give, disclose and release information. The revocation is effective only as to those entities to whom the written statement revocation is given and only after the time of delivery. I also understand that I have the right to inspect the disclosed information at any time. I know that once the information I have authorized to be released is released it is subject to re-disclosure by the recipient and is no longer protected by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto, as amended from time to time.

THE AUTHORITY TO ACT AS PERSONAL REPRESENTATIVE

I grant to said agent the power and authority to serve as the personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and its regulations (HIPAA) during any time that my agent (hereinafter referred to in subsequent clauses of this paragraph as my "HIPAA personal representative") is exercising authority under this document.

Pursuant to HIPAA, I specifically authorize said personal representative to request, receive and review any information regarding my physical or mental health, including without limitation all HIPAA-protected health information, medical and hospital records; to execute on behalf of my said child(ren) any authorizations, releases, or other documents that may be required in order to obtain this information and to consent to the disclosure of this information. I further authorize my HIPAA personal representative execute on behalf of my said child(ren) any documents necessary or desirable to implement the health care decisions that said HIPAA personal representative is authorized to make.

The singular or plural, masculine or feminine gender, shall be construed according to the context of the sentences and paragraphs, including the acknowledgment below.

Dated _____.

STATE OF IOWA; COUNTY OF _____ ss.

Signed and sworn to (or affirmed) before me on _____, by _____.

Signature of Notary Public