AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(Valid Authorization Under 45 CFR Chapter 164
and the Laws of the State of Texas)

Statement of Intent

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits use, disclosure or release of my individually identifiable health information (or, sometimes herein, "protected medical information"). This Authorization is being signed because it is crucial that my health care providers readily use, release or disclose my protected medical information to, or as directed by, that person or those persons designated in this Authorization in order to allow me the advantage of being able to discuss with, and obtain advice from, others or to facilitate decisions regarding my health care when I otherwise may not be able to discuss these matters with health care providers without regard to whether any health care provider has certified in writing that I am "incompetent" for purposes of the laws of the State of Texas.

Appointment of Authorized Persons

I, **NELVA ERLEEN BRUNSTING**, also known as **NELVA E. BRUNSTING**, an individual, hereby appoint the following persons, or any of them, as Authorized Persons for health care disclosure under the Standards for Privacy of Individually Identifiable Health Care Information (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and [State Health Care Information Act]:

ELMER HENRY BRUNSTING, also known as ELMER H. BRUNSTING
CANDACE LOUISE CURTIS
CAROL ANN BRUNSTING
CARL HENRY BRUNSTING
AMY RUTH TSCHIRHART
ANITA KAY RILEY

Grant of Authority

Therefore, as authorized by 45 CFR Sec(s). 164.502(a)(1)(i) and (iv), 164.502(a)(2)(i), 164.524 and 164.528, a covered entity (being a health care provider as defined by HIPAA) is permitted to use, release and disclose my individually identifiable health information pursuant to and in compliance with this valid Authorization.

I hereby authorize:

a. All covered persons and entities as defined in HIPAA, including but not limited to a doctor (including but not limited to a physician, podiatrist, chiropractor, or osteopath), psychiatrist, psychologist, dentist, therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate,

b. to use, release and disclose the following information at the request of an Authorized Person:

   Any and all individually identifiable health care information, reports and/or records concerning my medical history, condition, diagnosis, testing prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my health care. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization for access to, disclosure and release of ANY protected medical information by or to the persons named in this Authorization as if each person were me;

c. to, or as requested by, an Authorized Person.

Termination

This Authorization is not affected by, and shall not terminate by reason of, my subsequent disability or incapacity. This Authorization shall terminate on the first to occur of: (1) 1 year following my death or (2) upon my written revocation expressly referring to this Authorization and the date it is actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. Such revocation shall be effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has taken action in reliance on it.

Re-disclosure

By signing this Authorization, I acknowledge that the information used, disclosed or released pursuant to this Authorization may be subject to re-disclosure by an Authorized Person

whose names are written in paragraph 1 of this Authorization and the information once disclosed will no longer be protected by the rules created in HIPAA. No covered entity shall require an Authorized Person to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this Authorization.

Instructions to the Authorized Persons

An Authorized Person shall have the right to bring a legal action in any applicable forum against any covered entity that refuses to recognize and accept this Authorization for the purposes that I have expressed. Additionally, an Authorized Person is authorized to sign any documents that the Authorized Person deems appropriate to obtain use, disclosure or release of the protected medical information.

Effect of Duplicate Originals or Copies

If this Authorization has been executed in multiple counterparts, each counterpart original will have equal force and effect. An Authorized Person may make photocopies of this Authorization and each photocopy will have the same force and effect as the original.

My Waiver and Release

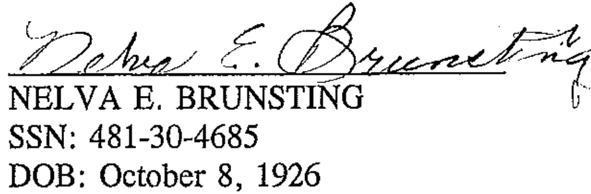
With regard to information disclosed pursuant to this Authorization, I waive any right of privacy that I may have under the authority of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), any amendment or successor to that Act, or any similar state or federal act, rule or regulation. In addition, I hereby release any covered entity that acts in reliance on this Authorization from any liability that may accrue from the use or disclosure of my protected medical information in reliance upon this Authorization and for any actions taken by an Authorized Person.

Severability

I intend that this authorization conform to United States and Texas law. In the event that any provision of this document is invalid, the remaining provisions shall nonetheless remain in full force and effect.

I understand that I have the right to receive a copy of this authorization. I also understand that I have the right to revoke this authorization and that any revocation of this authorization must be in writing.

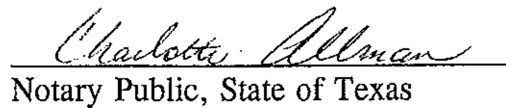
Dated: January 12, 2005.



NELVA E. BRUNSTING
SSN: 481-30-4685
DOB: October 8, 1926

STATE OF TEXAS
COUNTY OF HARRIS

This instrument was acknowledged before me on January 12, 2005, by NELVA E. BRUNSTING.



Notary Public, State of Texas