ON POINTE
REAL ESTATE & INVESTMENTS
INC

Authorization for Disclosure and Use of Protected Health Information

Authorization. I, _____, hereby authorize the disclosure and release of any of my individually identifiable health information and any other medical records ("my medical records") to the following person(s) who has or have been designated by me to act as my agent, attorney-in-fact, successor trustee, or other personal representative, hereafter referred to individually or collectively as "my agent."

Name of Agent	Address	Telephone
Name of Agent	Address	Telephone
Name of Agent	Address	Telephone

Purpose. This authorization is for the purpose of enabling my agent to carry out the agent's duties toward me, as determined by my agent, including (but not limited to) making a determination as to my incapacity for purposes of establishing my agent's authority to act on my behalf. I intend that my agent shall be treated as I would be regarding the use and disclosure of my medical records.

Persons authorized. The persons or entities who are authorized to disclose and release my medical records to my agent are my treating physicians and any other person, entity, or entities who is or are in possession of my medical records and subject to the privacy requirements of the Health

Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. Section 1320d and 45 CFR parts 160, 164, or any successor legislation, and the California Confidentiality of Medical Information Act, Civil Code Sections 56 to 56.37, or any successor legislation.

Effective date and duration. This authorization is effective immediately. It will remain in effect until one year after my death, unless terminated earlier by operation of law or revoked by me.

Right to revoke. I understand that I may revoke this authorization at any time by signing a written statement of revocation and delivering it to any person acting as my agent or to any physician or entity holding my protected health information. I also understand that any such revocation will not be effective with regard to any protected health information released to my agent by any person acting in good faith reliance on this authorization without actual knowledge of the revocation.

No conditions imposed. I understand that a person or entity covered by this authorization may in limited circumstances legally condition treatment, payment, enrollment, or eligibility for benefits on whether I sign an authorization. I am signing this authorization for the purpose of planning for incapacity and not as a condition imposed by any person or entity.

Redisclosure of information. My agent may not redisclose my protected health care information except as required or permitted by law. I understand that any information redisclosed by my agent may no longer be protected by HIPAA regulations.

Release from liability. I release any person relying on this authorization from any liability arising from the release of my medical records to my agent in reliance on this authorization while it is in effect.

Copies. A copy of this authorization may be used in place and instead of the original.

Date: _____

Signature: _____

Printed Name: _____

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714-908-8200

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Corona, CA 92882

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Certificate of Acknowledgment of Notary Public

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
) SS
County of _____)

On _____, 20__, before me, _____

personally appeared _____,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing is true and correct.

WITNESS my hand and official seal.

_____

Notary Public for the State of California

[NOTARY SEAL]

My commission expires: _____