HIPAA Right of Access Form for Family Member / Friend

I _____, direct my health care and medical/dental services providers and payers to disclose and release my protected health information described below to:

Name: Relationship:

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above
(Check either A or B):

___ A. **Disclose** my complete health record (including but not limited to diagnosis, lab tests, prognosis, treatment, and billing for all contiditons) **OR**

___ B. Disclose my health record as above, **BUT do not disclose** the following (check as appropriate):

___ Mental health records
___ Communicable diseases (including HIV and AIDS)
___ Alcohol/drug abuse treatment
___ Other (please specify): _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

___ An electronic record or access through an online portal
___ Hard Copy

This authorization shall be effective until (Check one):

___ All past, present, and future periods, OR
___ Date of event: _____
Unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care provider preferably in writing.)

_____ _____
Name of Individual giving this Authorization Date of Birth

_____ _____
Signature Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. 5 164.5