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HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical service 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 conditions) ***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)***: _____

This authorization shall be effective until ***(CHECK ONE)***:

☐ All past, present, and future periods, ***OR***

☐ Date or event: _____

Unless I revoke it. ***(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing)***

_____ _____
NAME OF INDIVIDUAL GIVING THIS AUTHORIZATION DATE OF BIRTH

_____ _____
SIGNATURE OF INDIVIDUAL GIVING THIS AUTHORIZATION DATE