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HIPAA Right of Access Form for Family Member/Friend

I, ______________________________, direct my health care and medical 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 diagnoses, 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): ______________________________

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 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 the Individual Giving this Authorization **Date of birth**

______________________________ __________

Signature of the Individual Giving this Authorization **Date**

______________________________ __________