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: **ENTER NAME AND RELATIONSHIP BELOW**:

Name: ___________________________
Relationship: ____________________

Name: __________________________
Relationship: ____________________

Health Information to be disclosed upon the request of the person named above:

(•) Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

( ) Disclose my health record as above, BUT do not disclose the following Mental health records including communicable diseases (ie; HIV and AIDS), alcohol/ drug abuse treatment etc...

This authorization shall be effective for all past, present and future periods unless I revoke it or specify a date below.(NOTE: You may revoke this authorization at any time by notifying your health care providers.)

Signature: ____ Date: __________________