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 & 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

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524 Resource provided by the ABA Commission on Law and Aging | www.americanbar.org/aging