South Florida Rheumatology
Broward's First Rheumatology Practice

Charles B. Kahn, M.D., F.A.C.P., F.A.C.R.
Wayne G. Riskin, M.D., F.A.C.P., F.A.C.R.
Yesenia Santiago-Casas, M.D., F.A.C.P., F.A.C.R.
Linnette Lopez, M.D., F.A.C.R.
Lynette Nicholson, M.M.S., PA-C

**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):

_____

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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