HIPAA RIGHT OF ACCESS FORM FOR FAMILY MEMBER/FRIEND

If you would like to give permission for a friend or family members to access your medical information, please complete this form below and bring a copy with you to the office on your appointment day.

Your Name: *

Date of birth: *

1 Relationship Name*

Relationship

Email *

2 Relationship Name*

Relationship

Email *

☐ Please send me updates, special offers and appointment updates through email

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Health Information to be disclosed upon the request of the person name 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

Form of Disclosure

☐ 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 provider.)

Patient Signature*

Date:

_____ _____

Print form and bring to your appointment