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:

_____

Name: _____ Relationship: _____

Contact Information:

_____

Health information to be disclosed upon the request of the person(s) named above

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

○ Disclose my health records 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): _____

Forms 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

The authorization shall be effective until:

○ 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:_____ Date of Birth: _____

_____ _____

Client Signature Date