

## 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 and 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

