Sample 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