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