HIPAA Right of Access Form for Family Member/Friend

I, ________________________________, direct MedCare Family Practice/MedCare Urgent Care 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).

_____ 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): _________________________________

The form of disclosure will be (1) an electronic record or access through an on-line portal, (2) hard copies of medical records, and/or (3) telephone communication.

This authorization shall be effective until (Check A or B):

_____ A. All past, present, and future periods,

_____ B. Date or event:____ unless I revoke it by sending a signed, written letter.

_______________________________________ _______________________
Patient Name (Printed) Date of birth

_______________________________________ _______________________
Patient Signature Date