MedCare

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct MedCare 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. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers.)

_____ _____

Name of the Individual Giving this Authorization Date of birth

_____ _____

Signature of the Individual Giving this Authorization Date