## 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 & AIDS)
   Alcohol/Drug Abuse Treatment
   Other (please specify) __________________________________________________

**Form of Discloser** (unless another format is mutually agreed upon between my provider and designee):

**Electronic Record** or access via **Online Portal**
**Hard Copy of Medical Record**

This authorization shall be effective until **(Check one)**:
All past, present, and future periods, OR
Date or Event: ________________________________________________________
Unless I revoke this authorization. (**NOTE:** You may revoke this authorization in writing at any time by notifying your Waimea Primary Care Provider)

________________________________________________ ______________________
Name of the Individual Giving Authorization (Patient) Date of Birth

________________________________________________ ______________________
Signature of the Individual Giving Authorization Date Signed

Internal Use: DrC#_____________________ Received by: _____________________________