HIPAA Right of Access Form

I, _____, as legal guardian for _____ ,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.

Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) _____

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 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 Patient Name

Patient Date of Birth_____

_____

Signature of the Individual Giving this Authority