FOOT & ANKLE PREMIER SPECIALISTS

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 diagnoses, X-rays, lab tests and results, prognosis, treatment, and billing, for all conditions) **OR**

☐B. **Disclose** my health record, as above, **BUT do not disclose the following**
(Check as appropriate):

- ☐ Diagnoses
- ☐ X-rays
- ☐ Lab test and results
- ☐ Billing
- ☐ Other (please specify)

_____

_____

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

☐An electronic record by email

☐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 or 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