Barnes Professional Eye Care

HIPAA Right to Access Form for Family Members/Friend

I, _____, authorize all medical records/diagnoses/protected health information to be disclosed and release to the person(s) listed below:

Name:	Relationship:	Phone Number:	Date Of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Health information to be disclosed upon the requested of the person named above (check either A or B)

☐ A. **Disclose** my complete health records (including but not limited to diagnosis, lab tests, prognosis, treatment, and billing for all conditions)

☐ B. **Disclose** my health records, as above, BUT DO NOT DISCLOSE the following (check as appropriate)

- ☐ Communicable Diseases
- ☐ Other (please specify):

_____

_____

The authorization shall be effective until (check one):

☐ All past, present, and future periods

☐ Date or event: _____

You may revoke this authorization anytime by notifying the office of this change, in writing.

_____ _____

Name of the Individual Giving the Authorization | Date of Birth

_____ _____

Signature of the Individual Giving the Authorization | Date

Note: HIPAA Authority for Rights of Access: 45 C.F.R.§ 164.524