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HIPAA Right of Access Form for Family Member/Friend

I, ___________________________________, **do** / **do not** authorize my dental service providers to disclose pertinent protected health care information to the **following** / **no one** should I not be available:

Name: Relationship:

_______________________________________ _____________________________________

Contact information: ____________________

Health information to be disclosed upon the request of the person named about (check A or B):

____ A. **Disclose** my complete health and dental records (including but not limited to health history, registration information, diagnoses, x-rays, referrals, prognosis, treatment, billing and account information **-OR-**

____ B. **Disclose** my health information as above, **BUT do not disclose** the following (circle as applied):

Billing and Account Information

Medical Health History

Diagnoses and Treatment

Registration Information

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 (circle one):

All past, present, and future periods

Date or event: __________________________

Unless I revoke it

____ _____________________

Print Name of Individual Giving This Authorization Date of Birth

____ _____________________

Signature of Individual Giving This Authorization Today's Date