HIPAA Right of Access Form for Family Member/Friend

I, _____, direct IMAGE EYE CARE to disclose and release my protected health information described below to:

Name: _____ *Relationship:* _____

Address: _____ _____ _____ *Phone:* _____ *Email:* _____

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 and AIDS)
____ Alcohol/drug abuse treatment
____ Other (please specify): _____

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 (Check one):
_____ All past, present, and future periods, OR
_____ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying IMAGE EYE CARE, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization *Date of birth*

_____ _____
Signature of the Individual Giving this Authorization *Date*

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

1120 Wolfrum Road, Suite 106, Weldon Spring, MO 63304 • Ph:636.447.2244 • Fax: 636.447.2213 • www.ImageEyeCareSTL.com