FOCUS PHYSICAL THERAPY

Patient Name:_____DOB:_____

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 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):

☐ Verbal
☐ An electronic record
☐ 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 at any time by notifying your health care providers, 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