RIGHT OF ACCESS FORM

I,_____, direct my health care and medical service providers and payers to disclose and release my protected health information described below to:

Name:_____

Health Information to be Disclosed upon the request of the person named above:

____A. Disclose my complete health record (including but not limited to diagnosis, 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 Disease (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, access electronically 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:_____

Note: You may revoke this authorization at any time by notifying your health care providers 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