Rabe Family Dentistry, P.C.

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)
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 / Verbal Conversation

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 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.