OSTEOPATHIC FAMILY WELLNESS CENTER
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Board Certified in Family Medicine and Osteopathic Manipulative Treatment

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, DOB, Relationship, Contact Phone Number:
_____
_____
_____
_____

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 results, 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 on):

- 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