WEBSTER
EYE CARE ASSOCIATES

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:
Address:_____
Phone Number:_____

Health Information to be disclosed upon the request of the person named above:
(Circle 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:

_____

_____

This authorization shall be effective until:
(Circle either **A** or **B**)

A. All past, present, and future periods

B. Date or event: _____

NOTE: You may revoke this authorization in writing at any time by notifying your health care providers.

_____ _____
PRINT: Name of the Individual Giving this Authorization Date of Birth

_____ _____
Signature of the Individual Giving this Authorization Today's Date

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