**HIPAA Right of Access/Disclosure Form For Family/Friend**

(disregard this form if you do not wish to have any medical information shared with others)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize North San Antonio Family Medicine to discuss my personal medical information with the following person/people:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization shall be effective until (**Check one**):

\_\_\_\_\_\_All past, present, and future periods, OR

\_\_\_\_\_\_Date or event:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Information to be disclosed upon the request of the person/people 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may revoke this authorization at any time. If I wish to revoke it I will contact North San Antonio Family Medicine via phone or in writing. The revocation will be valid as of the date and time that North San Antonio Family Medicine confirms receipt of my message to revoke.

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_