CHENANGO EYE ASSOCIATES
HIPAA RIGHT OF ACCESS FORM FOR FAMILY MEMBER/FRIEND

PATIENT NAME:	DOB:	ACCOUNT NUMBER:

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)

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): _____

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

Patient Signature: _____ **Date**: _____

(In Office Only)
Processed by: