HIPAA Right of Access For Family/Friend

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

I, _____, give permission for my health care provider(s) to share my protected health information (PHI) described below with the following people:

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship**: _____ **Phone:** _____

Name: _____ **Relationship**: _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Health information Contentnea Health is allowed to share: (Check **either** A or B.)

☐ A. My medical and/or dental health record, including but not limited to any diagnoses, lab tests, prognosis, treatment, and billing. ***Note**: Even if you choose this option, Contentnea Health will **not** share psychotherapy progress notes or substance abuse treatment notes without express written consent from the patient. **OR**

☐ B. My medical and/or dental record as stated above, but **DO NOT** share the following:

☐ Communicable diseases (including HIV and AIDS)

☐ Other (Please specify.) _____

I understand my health record can be shared via electronic record/provider portal, hard copy, or another way that is mutually agreed upon between by provider and designee.

This authorization shall be in effect 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 provider(s), preferable in writing.

_____ _____

Printed Name of Person Giving this Authorization **Date of Birth**

_____ _____

Signature of the Individual Giving this Authorization **Date**