*** OPTIONAL ***

Patient Name (Last, First MI): _____

Date of Birth: _____ /_____ /_____

Authorization to Disclose Health Information to Family or Other Designated Persons

I, _____, direct my health care and medical services providers and payers to
(Name of the Individual Giving this Authorization)
disclose and release my protected health information described below to:

Designated Person Information:

First Name: _____ **MI:** _____ **Last Name:** _____

Phone #: (_____) _____ - _____ **Relationship to Patient:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Health Information to be disclosed upon the request of the person named above (choose either A or B below):

☐ **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): _____

Form of Disclosure: An electronic record or access through an online portal Hard copy (unless another format is mutually agreed upon between my provider and designee)

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 providing written notice to your health care provider(s).)

Signature: _____ **Date:** _____

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

*** OPTIONAL ***