PRIVIA MEDICAL GROUP

HIPAA RIGHT OF ACCESS FORM FOR PATIENT'S FAMILY MEMBER / FRIEND

I, _____, direct my health care provider to disclose and release my protected health information (PHI) as described below to:

Name(s): _____ Relationship: _____

Phone and Address: _____

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): _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

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 provider, preferably in writing.)

I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on me signing this Authorization.

I understand that once my PHI is shared with the person(s) designated in this Authorization, such person(s) may re-disclose my PHI and it is no longer protected by the HIPAA Privacy Rule

_____ _____

Printed Name of the Individual Giving this Authorization | Date of birth

_____ _____

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