Active Health
PHYSICAL THERAPY

Patient Name: _____ DOB: _____

HIPAA Right of Access Form for Family Member/Friend

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): _____

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

☐ Verbal
☐ An electronic record ☐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 at any time by notifying `

_____ _____

Name of the Individual Giving this Authorization Date of birth

_____ _____

Signature of the Individual Giving this Authorization Date

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