HIPAA Right of Access/Disclosure Form For Family/Friend

(disregard this form if you do not wish to have any medical information shared with others)

I, _______________________ hereby authorize Elizabeth Clanton, MD to discuss my personal medical information with the following person/people:

Name:____ Relationship: ___________________

Name:____ Relationship: ___________________

Name:____ Relationship: ___________________

Name:____ Relationship: ___________________

This authorization shall be effective until (**Check one**):

______All past, present, and future periods, OR

______Date or event:___________________

Health Information to be disclosed upon the request of the person/people 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): _________________________

I understand that I may revoke this authorization at any time. If I wish to revoke it I will contact Elizabeth Clanton, MD via phone or in writing. The revocation will be valid as of the date and time that Elizabeth Clanton, MD confirms receipt of my message to revoke.

Patient Name:____

Patient Signature:____ Date:_____________________