BRANCHVIEW
Dental Care
Beautiful Smiles, Endless Possibilities

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical/ Dental services providers and payers to disclose and release my protected health information described below to:

Name: _____ Relationship: _____

Contact information (address and Phone#):

_____

_____

***Health Information to be disclosed upon the request of the person named above -- (Circle 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

◯ Verbal phone and/or in person

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 providers, preferably in writing.)

_____ _____

Name of the Individual Giving this Authorization **Date of birth**

_____ _____

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

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