HIPAA Authorization Form for Family Members/Friends

I, ______________________________________, give permission to all my health care and medical services
(Please Print Name)
providers and payers to disclose and release my protected health information described below to:

Full Name(s):	**Relationship to patient:**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Health Information to be disclosed (Check all that apply):

☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

OR

☐ My complete health record, as above, with the exception of the following information: (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): ______________________________
  ____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Please 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(s) in writing.)

______________________________ ______________________________
Printed Name of the Individual Giving this Authorization | Relationship to patient

______________________________ ______________________________
Signature of the Individual Giving this Authorization | Date Signed

______________________________ ______________________________
Witness / Staff Signature | Date Signed