Integrace
COPPER RIDGE

The Senator William and Ellen Proxmire Memory Clinic
At Copper Ridge

HIPAA Right of Access Form for Family Member(s)/Friend(s)

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

Name:	*Relationship:*	*Phone:*
____________________	________________	________________
____________________	________________	________________
____________________	________________	________________

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 condition) 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) – check all that apply:

☐ Verbally either in person, telephone, or other verbal communication
In writing either via email, written letter, or other form of writing

☐ 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 healthcare providers, preferably in writing).

______________________________________ ________________________
Name of Individual Giving this Authorization Date of Birth

______________________________________ ________________________
Signature Date

EQUAL HOUSING OPPORTUNITY