WINDERMERE MEDICAL GROUP
EXCELLENCE IN PRIMARY CARE!

HIPAA Right of Access Form for Family Member/Friend

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

I,_____give permission to my health care providers to share my protected health information described below with:

Name: _____ *Relationship:* _____ Phone_____

Name: _____ *Relationship:* _____ Phone_____

Name: _____ *Relationship:* _____ Phone_____

Name: _____ *Relationship:* _____ Phone_____

I authorize Windermere Medical Group to share my Health Information: (Check **either** A or B)

_____ A. Share my medical health record (including but not limited to any diagnoses, lab tests, diagnostic imaging, prognosis, treatment, and billing.*)*

OR

_____ B. Share my medical record as stated above, but **DO NOT share the following:**

_____ Communicable diseases (including HIV and AIDS)

_____ Other (please specify): _____

I understand that my health record can be shared via electronic record/provider portal, hard copy, or another way that is mutually agreed upon between my provider and designee.

This authorization shall be in effect for (Check **one**):

_____ All past, present, and future periods.

OR

____ Unless I revoke it in writing.

_____ _____

Printed Name of Person Giving this Authorization Date of Birth

_____ _____

Signature of the Individual Giving this Authorization Date