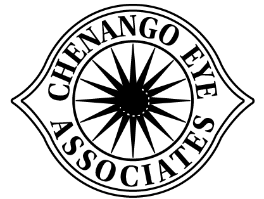
**CHENANGO EYE ASSOCIATES**   
**HIPAA Right of Access Form for Family Member/Friend**

|  |  |  |
| --- | --- | --- |
| Patient Name: | DOB: | Account number: |

I , \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:  
  
**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| (In Office Only) Processed by: |