# 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 for my health care providers to share my protected health information described below with:

*Name:* _____ *Relationship:* _____ Phone_____

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*Name:* _____ *Relationship:* _____ Phone_____

**Health information Greene County Health Care is allowed to share:** (Check **either** A or B)

_____ A. Share my medical and/or dental health record (including but not limited to any diagnoses, lab tests, prognosis, treatment, and billing. **Note: Even if you choose this option, GCHC will not share psychotherapy progress notes or substance abuse treatment notes without express written consent from the patient.)* **OR**

_____ B. Share my medical and/or dental 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 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.)*

_____ _____

Printed Name of Person Giving this Authorization — Date of Birth

_____ _____

Signature of the Individual Giving this Authorization — Date