

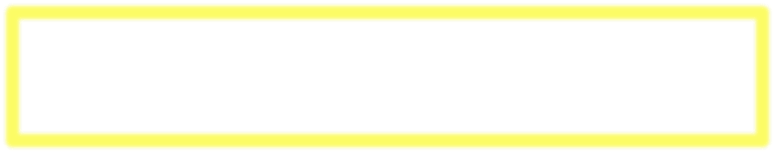
**HIPAA Right of Access Form**

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

Company Name: *Holistic Aging/Options for Elder Care Life Care Manager*

Name*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Cell Phone: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Relationship: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* E-Mail: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*



**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): |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):  An electronic record or access through an online portal

 Hard copy

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.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the Individual Giving this Authorization Client's date of birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of the Individual Giving this Authorization Date

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

Resource provided by the ABA Commission on Law and Aging | www.americanbar.org/aging