HIPAA Authorization Form for Family Members/Friends

I, _____, give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s):	*Relationship:*
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply)**:**

☐ My complete health record (including but not limited to diagnoses, lab tests prognosis, treatment and billing, for all conditions) OR

☐ My complete health record as above, with the exception of the following information: (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify _____

_____

This health information may be used to enable the persons I authorize to know and unders and my condition and my treatment or treatment options, for treatment or consul ation, for claims payment purposes or related reasons.

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.)

_____
Print n ume of the individual giving this authorization

_____ _____
Signature of the individual giving this authorization Date