HIPAA Right of Access Form for Family Member / Friend

I, _____, authorize Christian Healthcare Specialists to disclose and release my protected health information as described below to the following individual(s):

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Check either A or B:

A. _____ Disclose my complete health record (including but not limited to diagnoses, lab tests, Prognosis, treatments, etc., for all conditions)

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 Use and Treatment
- _____ Other (Please specify below)

_____

_____

_____

This authorization shall be effective until (check one):
- _____ All past, present, and future periods
- _____ Date or event: _____

Unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying Christian Healthcare Centers in written form).

_____ _____

Print Name Birthdate

_____ _____

Signature Today's Date