

Herkert Family Eye Care, P.C.

6904 S. East St., Suite C
Indianapolis, IN 46227
Staffhfec@outlook.com

Phone: 317-784-5665
Fax: 317-784-7011

HIPAA Right of Access Form for Family Member/Friend

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)

- Disclose** my complete health record (including but not limited to diagnoses, Lab tests, prognosis, treatment, and billing for all conditions) **OR**
- 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 in writing).

Name of the Individual Giving this Authorization

Date of birth

Signature of the Individual Giving this Authorization

Date