West Plano Pediatrics
HIPAA Right of Access Form for Family Member/Friend
(For Patients being seen without a parent in attendance)

I, ______________________, Telephone Number ___________________, 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)

☐ A. Disclose my complete health record (including but not limited to diagnoses , lab tests, prognoses, 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, AIDS or STDs)

☐ Alcohol/drug abuse/treatment

☐ Other (please specify):

____

____

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 provider.)

______________________________ ______________________________
Name of individual giving this authorization Date of Birth

______________________________ ______________________________
Signature Date