BREAST
BODY
BEAUTY

PLASTIC & RECONSTRUCTIVE SURGERY

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: _____

Telephone #: _____ Email: _____

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 about, **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 electric 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: _____
  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 Date of Birth

_____ _____

Signature of the Individual Giving this Authorization Date