Outpatient Medical Center, Inc.

HIPAA Right of Access Form

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to the following:

- Name: _____ Relationship: _____

  Contact information: _____

- Name: _____ Relationship: _____

  Contact information: _____

- Name: _____ Relationship: _____

  Contact information: _____

Health Information to be disclosed upon the request of the person(s) 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)

☐ B. Disclose my health record, as above, BUT do not disclose the following (check as appropriate):

☐ Mental health records ☐ Communicable diseases (including HIV/ AIDS)

☐ Alcohol/drug abuse treatment ☐ Other (please specify): _____

Forms 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, or physical accompaniment during clinical encounters

This authorization shall be effective until (Check one):

☐ All past, present, and future periods

☐ Date or event: _____

(**NOTE:** You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Printed Name of Individual Giving this Authorization _____

Signature of the Individual Giving this Authorization _____ Date: _____