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:

Name and Relationship: Hand in Hand Care, Personal Registered Nurse
Contact Info: Phone# (941) 363-1809 Fax# (941) 208-9386 Email: info@handinhandcare.net

Health Information to be disclosed: (Upon the request of the person named above)

☒ **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: ____

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
- ✓ Verbal

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, preferably in writing.)

______________________________	______________________________
Patient's Name	Patient's Date of Birth
Name of Patient or Individual Giving this Authorization	Relationship to Patient
Signature of Patient or Individual Giving this Authorization	Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524