HIPAA Right of Access Form

I, ______________________________, direct Drs Eyecare to disclose and release my protected health information to:

Name: ______________________________ Relationship: ______________________________

Contact information: ______________________________

Name: ______________________________ Relationship: ______________________________

Contact information: ______________________________

-Health Information to be disclosed upon the request of the people named above (circle choice) -

A. Disclose my complete health record (including but not limited to diagnoses, prescriptions,

lab tests, prognosis, treatment, and billing, for all conditions) **OR**

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

Mental health records

Communicable diseases (including HIV and AIDS)

Alcohol/drug abuse treatment

Other (please specify):

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-Form of Disclosure : Hard copy

This authorization shall be effective until: All past, present, and future periods, OR ______________________________ (date), unless I revoke it. (NOTE: You may revoke this authorization in **writing** at any time)

______________________________ ______________________________

Name of the Individual Giving this Authorization Date of birth

______________________________ ______________________________

Signature of the Individual Giving this Authorization Date