SIMMONS CLINIC
John C. Simmons, M,D.,F.A.C.S.
100 East Cahaba Ave.
Linden, Al. 36748
Phone# (334) 295-0170
Fax# (334) 295-2275

HIPAA 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: _____

Name: _____ Relationship: _____

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) **OR**

B. **Disclose** my health record, as above, **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 electronic 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 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.)

_____ _____
Printed Name of Patient giving Authorization Date of Birth

_____ _____
Signature of Patient giving Authorization Date