Oviedo Vision Center, PA
875 Clark Street
Oviedo, FL 32765
P (407) 366 - 7655 F (407)366 - 4129

HIPAA Right of Access Form for Family Members/Friend

This form provides your authorization to release your medical records from Oviedo Vision Center to any person listed. Print this form and complete it in its entirety. Please FAX, mail, e-mail or deliver the completed form.

Patient's name: _____

Address: _____

Date of birth: _____ Phone: _____

I, _____, direct Oviedo Vision Center to disclose and release my protected health information described below to:

Name:_____ Relationship: _____

Contact information: _____

_____

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 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 – Please check all that may apply):

- ☐ Verbal Authorization
- ☐ An electronic record
- ☐ Hard copy (production fees applied)

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.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 CFR § 164.524