Henry F. Crabbe, M.D., Ph.D.
5 Shaw's Cove, Suite 207
New London, CT
T-(860) 444-8877
F-(860)444-9660

HIPAA Right of Access Form for Family Member/Friend

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

Name: **Relationship:**

_____ _____

Telephone #:_____

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
  - ☐ Mental Health Records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):_____

    _____

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 provider, preferably in writing.)

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

_____ _____
Signature of the Individual Giving this Authorization Today's Date