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qualitycaremd.com

HIPAA Right of Access

Authorization for a Family Member or Friend

Type into the boxes on your computer, or print and fill in by hand.

I, direct my providers to disclose my
protected health information described below to the person(s) named here:

Family member / friend #1

Legal Name

Relationship Contact

Family member / friend #2

Legal Name

Relationship Contact

Health information to be disclosed upon request of the person(s) named above. Initial A or B:

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A. Disclose my complete health record (including diagnosis, lab results, prognosis, treatment, and billing) for all conditions.

OR

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

Mental health records, communicable diseases (including HIV and AIDS), and alcohol / drug abuse treatment.

Other (please specify):

Form of disclosure: information may be disclosed as an electronic record, through an online patient portal, by telephone, or as a hard copy. This authorization shall remain effective until you revoke it. You may revoke this authorization in writing at any time by notifying Quality Primary Care Associates.

Patient Name DOB Date

Signature

How to return this form

Email it to qpca@qualitycaremd.com, fax it to 833-989-2090, or bring it to any of our offices.

QUALITY PRIMARY CARE ASSOCIATES

Rockville: 50 West Edmonston Drive, Suite 404, Rockville, MD 20852

Gaithersburg: 818 West Diamond Avenue, Unit 130, Gaithersburg, MD 20878

Columbia / Elkridge: Chartwell Medical Center, 8186 Lark Brown Road, Suite 201, Elkridge, MD 21075