Phone 301-762-7723
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qualitycaremd.com

QUALITY PRIMARY CARE ASSOCIATES

HIPAA Right of Access

Authorization for a Family Member or Friend

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:

_____ **A.** Disclose my complete health record (including diagnosis, lab results, 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), 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 _____