Yvette Brindle-Decancq, LMHC, CBC
Licensed Mental Health Counselor
Certified Behavioral Consultant

HIPAA Right of Access Form

I, _____, **decline / direct** my health care and medical services providers and payers 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 may be **verbal and/or written** (unless another format is mutually agreed upon between my provider and designee):

This authorization shall be effective until (Check one):

_____ A. All past, present, and future periods

OR

_____ Date or event: _____

_____ _____

Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. §

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