

HIPAA Authorization Form for Family Member

Name: _____

Address: _____

City, State, ZIP Code _____

Email address: _____

Phone number: _____

Date: _____

Healthcare provider's name: _____

Healthcare provider's address: _____

City, State, ZIP Code: _____

Dear _____,

I, _____, hereby authorize the release of my protected health information (PHI) to the family members listed below, pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

1. Patient Information

Full Name: _____

Date of Birth: _____

Address: _____

City, State, ZIP Code: _____

Phone Number: _____

Email Address: _____

1. Family members Information:

Full Name: _____

Relationship to patient: _____

Address: _____

City, State, ZIP Code: _____

Phone Number: _____

Email Address: _____

Full Name: _____

Relationship to patient: _____

Address: _____

City, State, ZIP Code: _____

Phone Number: _____

Email Address: _____

Full Name: _____

Relationship to patient: _____

Address: _____

City, State, ZIP Code: _____

Phone Number: _____

Email Address: _____

2. Purpose of Disclosure: _____

3. Description of Information to Be Disclosed: _____

4. Persons Authorized to Make Disclosure: _____

5. **Persons Authorized to Receive Disclosure:** _____

6. **Duration of Authorization:** _____

7. **Right to Revoke Authorization:** I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken based on this authorization. Revocation of this authorization should be submitted in writing to the recipient listed in Section 2 of this form.

8. **Acknowledgment of Understanding:** I have read and understood the contents of this HIPAA Authorization Form, and I voluntarily sign it, knowing the purpose and consequences of authorizing the disclosure of my protected health information.

Patient's Signature: _____  Date: _____

Family member's Signature: _____  Date: _____

Healthcare provider's Signature: _____  Date: _____

Witnessed by: _____ Date: _____

Witness's Signature: _____ 

10. **Consent for Electronic Signature:** By signing this form electronically or by any means of electronic communication, I acknowledge and agree that my electronic signature is legally binding and has the same force and effect as a traditional handwritten signature.

Patient's Signature: _____  Date: _____