HIPAA Authorization Form for Family Members

Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **ZIP code:** _____

Email address: _____ **Phone number:** _____

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.

I. Patient information
Full name:
Date of birth:
Address:
City, State, ZIP code:
Phone number:
Email address:
II. Family members' information
Family member #1
Full name:
Relationship to patient:
Address:
City, State, ZIP code:
Phone number:
Email address:
Family member #2
Full name:
Relationship to patient:

Address:
City, State, ZIP code:
Phone number:
Email address:
Family member #2
Full name:
Relationship to patient:
Address:
City, State, ZIP code:
Phone number:
Email address:
III. Purpose of disclosure
IV. Description of information to be disclosed
V. Persons authorized to make disclosure
VI. Persons authorized to receive disclosure
VII. Duration of authorization

VIII. 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 II of this form.	
IX. 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:	
X. 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: