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: _____