premier VISION CLINIC

Jennifer DenHartog, O.D.

515-512-1444
12695 University Ave, Suite 170
Clive, Iowa 50325
PremierVisionClinic.com

Right of Access Form for Family Member/Friend

I, _____, 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 (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods,
  OR
- ☐ Date or event: _____

Unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____	_____
Name of the Individual Giving this Authorization	Date of birth
_____	_____
Signature of the Individual Giving this Authorization	Date of birth