Mind Rejuvenation, LLC
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HIPAA Right of Access Form for Family Member/Friend

Patient _____ **DOB** _____

Please list below any person(s) to whom we may inquire and/or inform about your general medical information, conditions or diagnosis. (PLEASE NOTE: These will be listed as Emergency Contacts UNLESS you specify below)

1. Name _____ Relationship _____

PLEASE INITIAL ALL THAT APPLY Phone _____

_____ Emergency Contact

_____ Complete health record (including, but not limited to diagnoses, lab tests, prognosis, treatment & billing)

2. Name _____ Relationship _____

PLEASE INITIAL ALL THAT APPLY Phone _____

_____ Emergency Contact

_____ Complete health record (including, but not limited to diagnoses, lab tests, prognosis, treatment & billing)

AFTER REVIEWING EACH SECTION BELOW, PLEASE INITIAL.

_____ (Initial) **AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION: I** authorize Mind Rejuvenation/AAIC to release my medical information and individually identifiable health information to me(us) or my(our) duly authorized representative (as noted above), representatives of local, state, or federal agencies and insurance companies or other organizations or entities as may be required to be permitted under federal or state law or for review or payment of claims. I further authorize Mind Rejuvenation/AAIC to release such information to physicians, hospitals or healthcare providers in order to treat me or to review my treatment. I understand that the specific information to be released may include, but is not limited to, history, diagnosis and/or treatment of drug or alcohol abuse, mental illness or communicable disease. I understand that I may revoke this authorization with a written and dated notice, except to the extent that disclosure of information has been made prior of receipt of revocation.

_____ (Initial) A**CKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONDITIONS OF TREATMENT:** The Notice of Privacy practices provides specific information and a complete description of how my personal health information may be used and disclosed. I(we) acknowledge that upon my request I(we) have been provided and have reviewed the Notice of Privacy Practices (dated June 1, 2018) and Conditions of Treatment. I(we) understand that as part of my healthcare, Mind Rejuvenation/AAIC will maintain health records describing my health symptoms, examination, test results, diagnosis, treatment and any plans for future care/treatment. I(we) understand this information is used to plan my care/treatment and bill for services provided. It is also used to communicate with other healthcare providers and in other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals as required or permitted by law without my consent.

_____ (Initial) **AUTHORIZATION TO CONTACT PATIENT/ACCOUNT REPRESENTATIVE:** I hereby authorize Mind Rejuvenation/AAIC physicians and staff to leave detailed information by mail, phone, text or email regarding lab results, clinical information and account balance(s).

_____ _____

Patient Signature **Date**