Family Member HIPAA Release Form

Date of Authorization: _____

Patient Information:

- **Full Name: _____**
- **Date of Birth: _____**
- **Contact Number: _____**

Authorized Family Member Information:

- **Full Name: _____**
- **Relationship to Patient: _____**
- **Contact Number: _____**

Scope of Authorization:
I authorize [Name of Family Member] to access:

- **☐ All Medical Records**
- **☐ Medication Records**
- **☐ Billing Information**
- **☐ Appointment Details**
- **☐ Other: _____**

Purpose of Authorization:

- **☐ Ongoing Medical Care**
- **☐ Emergency Decision Making**
- **☐ Legal Use**
- **☐ Other: _____**

Duration of Authorization:
This authorization will remain effective until:

- ☐ **Revoked by me in writing**
- ☐ **Specific Date: _____**

Patient Rights Acknowledgment:

I understand that I can revoke this authorization at any time and that this form does not waive any of my HIPAA rights.

Signature of Patient: _____

Date: _____

Signature of Family Member: _____

Date: _____