BARRON
CARE MANAGEMENT

HIPAA Right of Access Form

I, _____, direct health care and medical service providers and payers to disclose and release protected health information for:_____ to the individual(s) described below to:

Name: *Kate Barron and all associates of Barron Care Management*
Relationship: *Geriatric Care Manager(s)*

Contact information: __*info@barroncaremanagement.com*, *843-801-1608*_____
_____

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): (Check one or both)

- □ 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.)

_____ _____
(print) Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date