Natural Health Care
Jared L. Zeff, ND, Lac, LLC 3606 Main St., Suite 201 Vancouver, Washington 98663
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HIPPA Right of Access Form for Family Member/Friend –
AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION

I, ________________________________, direct the Salmon Creek Clinic and Dr. Jared Zeff, to disclose and release my protected health information described below to:

Recipient: I authorize my health care information to be released to the following recipient(s):

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.** [1]

☐ 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

[1] NOTE: HIPPA Authority for Right of Access: 45 C.F.R. § 164.524

Confidential

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☐ Date or event: ____
Unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying the Salmon Creek Clinic or Dr. Jared Zeff, preferably in writing.)

____ ___________________
Name of the Individual Giving this Authorization Date of birth

____ ___________________
Signature of the Individual Giving this Authorization Date

____
Witness

Confidential