HIPAA Right of Access / Representative Form for Family Member/Friend

By signing below, I understand that I am identifying, authorizing, and granting permission to the Personal Representative identified below to have authority to access my protected health information (PHI) and to assist in my treatment by UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy as described below:

Representative's Name: _____ Relationship to Patient:_____

Address: _____ Telephone #:_____

Health Information to be Disclosed to the Representative upon Request:

- I understand that by completing this form I am allowing the release of any and all information held by UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy (including, but not limited to information about my medications, medical condition, billing records, and drug handouts) to be shared with and disclosed to my Personal Representative.
- I understand the information released could relate to the following: Family Planning/Abortion, Alcohol, drug, or substance abuse information, AIDS, HIV-related information (including AIDS related testing and results), Mental Health, Sexually Transmitted Disease/Venereal Disease information, Genetic information, and Tuberculosis.
- I understand that any information disclosed pursuant to this form may be re-disclosed to other parties and no longer protected by the privacy regulations.

Duration of Access:

- I understand the designated Representative will have access to my information unless and until access is revoked by me.
- I understand that I may revoke this form and designation at any time by notifying UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy in writing. If the authorization is revoked, it will not have any effect on any actions taken by UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy prior to their receipt of the revocation.

I understand that signing this form is voluntary and that I do not have to sign this form. I understand that signing this form will not affect my ability to obtain treatment from UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy, any payment for treatment or enrollment or eligibility for benefits.

Signature of Patient: _____Date: _____