SPRINGFIELD
FAMILY PHYSICIANS

541-747-4300
Marcola Clinic – Centennial Clinic – Suzanne Way Clinic

RIGHT OF ACCESS FOR FAMILY/FRIEND (HIPAA)

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid, and it will not be possible for your health information to be shared as requested.

I, _____, direct my health care and medical service providers to disclose and release my protected health information described below to:

Name: _____ Relationship: _____

Contact information: _____

Name: _____ Relationship: _____

Contact information: _____

My Health Information can be disclosed upon the request of the person named above –

BUT DO NOT DISCLOSE THE FOLLOWING CHECKED ITEMS (check as appropriate):

_____Mental health records

_____ Communicable diseases (including HIV/AIDS)

_____Alcohol/drug abuse treatment

_____Genetic information

_____Other (please specify):

_____

Form of disclosure (unless another format is mutually agreed upon between my provider and designee) will be an electronic record via access through an online portal, hard copy, or verbally.

This authorization shall remain in effect unless you request a change and will replace any previous form on file. You may revoke this authorization in writing at any time by notifying Springfield Family Physicians.

Name of Patient _____ Date of Birth _____

Signature _____Todays Date _____