HIPAA Right of Access Form for Family Member/Friend

I, _____, direct W Financial Services, Inc. to disclose and release my protected health information described below to:

Name: _____

Relationship: _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above:

☐ A. Disclose my policy information (including but not limited to coverage, premiums, exclusions, claims procedures and billing, for all conditions)

☐ B. Disclose information on claims (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions),

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 by me and W Financial Services, Inc):

☐ An electronic record or access through an online portal or via email

☐ Hard copy

☐ Details provided via phone conversation

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 W Financial Services, Inc., preferably in writing.)

_____ _____

Name of the Individual Giving this Authorization Date of birth

_____ _____

Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R.