



COMPASS ONCOLOGY
Right of Access form for Family Member/Friend

HIPAA requires Health care providers to protect the privacy of your health information. However, if you don't object, a health care provider may share relevant information with family members or friends involved in your health care in certain circumstances.

This does not include copies of your Health Records; these must have a signed authorization from the patient only.

These family and friends are Not to be considered as emergency contacts.

The family members and friends listed below are involved in my care and can access information from my providers and staff.

I understand I have the right to change my mind and revoke access to any of the listed family or friends listed below.

I _____, allow my health care providers and their staff to share relevant information with the following listed family members or friends involved in my care.

Name: Relationship: Phone #

Name: Relationship: Phone #

Name: Relationship: Phone #

Name: Relationship: Phone #

Name: Relationship: Phone #

PATIENT PRINTED NAME

DATE OF BIRTH

PATIENT SIGNATURE

TODAY'S DATE

ANY FAMILY MEMBER OR FRIEND NOT LISTED ON THIS FORM IS RESTRICTED FROM ANY RIGHT TO ACCESS MY HEALTH INFORMATION.

FOR OFFICE USE
MRN: Entered into Centricity Entered into G2 Employee Initials: