FIRST MEDICAL ASSOCIATES
YOUR HEALTH, OUR PRIORITY

301-515-2901
866-701-4905
www.DrsFirst.com

FIRST MEDICAL ASSOCIATES HIPPA RIGHT OF ACCESS FORM FOR FAMILY MEMBER/FRIEND

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

1) Family member/friend's Legal Name: _____
   Relationship: _____
   Contact information: _____

2) Family member/friend's Legal Name: _____
   Relationship: _____
   Contact information: _____

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

Initial A or B

_____ **A.** Disclose my complete health record (including but not limited to diagnosis, lab results, prognosis, treatment, and billing, for all conditions

OR

_____ **B.** Disclose my health record, as above BUT do not disclose the following:
Mental health records, communicable diseases (including HIV and AIDS)
Alcohol/Drug abuse treatment, Other (please specify): _____
_____

Form of Disclosure: An electronic record or access through an online portal, via telephone or hard copy will be disclosed. This authorization shall be effective until you revoke it. (You may revoke this authorization in writing at any time by notifying your health care provider)

_____	_____	_____
Patient's full name giving this authorization	Date of Birth	Date Signed

12800 Middlebrook Rd. Suite 400 Germantown, MD 20874
806 West Diamond Ave Suite 110 Gaithersburg, MD 20878
9601 Blackwell Road Suite 210 Rockville, MD 20850
8600 Snowden River Pkwy Suite 207 Columbia, MD 21045
14300 Gallant Fox Ln, Suite 110 Bowie, MD 20715
9801 Georgia Ave. Suite 229 Silver Spring, MD 20902
1415 S Mountain Rd. Suite 100 Joppa, MD 21085