HIPAA Authorization Form for Family Members

Name: Julian Santiago **Date:** August 7, 2024

Address: 123 Maple Lane

City: Springfield **State:** IL **ZIP code:** 62701

Email address: julian.santiago@email.com **Phone number:** (217) 555-0123

Healthcare provider's name: Dr. Elena Torres

Healthcare provider's address: 456 Health Center Drive

City: Springfield **State:** IL **ZIP code:** 62701

Dear Dr. Torres,

I, Julian Santiago, hereby authorize the release of my protected health information (PHI) to the family members listed below, pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

I. Patient information
Full name: Julian Santiago
Date of birth: February 15, 1985
Address: 123 Maple Lane
City, State, ZIP code: Springfield, IL 62701
Phone number: (217) 555-0123
Email address: julian.santiago@email.com
II. Family members' information
Family member #1
Full name: Isabel Santiago
Relationship to patient: Spouse
Address: 123 Maple Lane
City, State, ZIP code: Springfield, IL 62701
Phone number: (217) 555-0456
Email address: isabel.santiago@email.com
Family member #2
Full name: Carlos Santiago
Relationship to patient: Brother

Address:	789 Pine Street
City, State, ZIP code:	Chicago, IL 60605
Phone number:	(312) 555-0789
Email address:	carlos.santiago@email.com
Family member #2	
Full name:	Maria Fernandez
Relationship to patient:	Mother
Address:	321 Oak Avenue
City, State, ZIP code:	Springfield, IL 62704
Phone number:	(217) 555-0987
Email address:	maria.fernandez@email.com

III. Purpose of disclosure

To coordinate ongoing medical care and provide updates on health status

IV. Description of information to be disclosed

Medical history, treatment plans, test results, and upcoming appointments

V. Persons authorized to make disclosure

Dr. Elena Torres and her medical staff

VI. Persons authorized to receive disclosure

Isabel Santiago, Carlos Santiago, Maria Fernandez

VII. Duration of authorization

This authorization is valid for one year from the date of signature.

VIII. Right to revoke authorization	
I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken based on this authorization. Revocation of this authorization should be submitted in writing to the recipient listed in section II of this form.	
IX. Acknowledgment of understanding	
I have read and understood the contents of this HIPAA Authorization Form, and I voluntarily sign it, knowing the purpose and consequences of authorizing the disclosure of my protected health information.	
Patient’s signature: Julian Santiago	Date: August 7, 2024
Family member’s signature: Isabel Santiago	Date: August 7, 2024
Healthcare provider’s signature: Dr. Elena Torres	Date: August 7, 2024
Witnessed by: Emily Johnson	Date: August 7, 2024
Witness’s signature: Emily Johnson	
X. Consent for electronic signature	
By signing this form electronically or by any means of electronic communication, I acknowledge and agree that my electronic signature is legally binding and has the same force and effect as a traditional handwritten signature.	
Patient's signature: Julian Santiago	Date: August 7, 2024