WELLNESS MEDICAL CENTER LLC

ELIZABETH LIU, M.D., PH.D.

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Dear Patients of Dr. Liu,

We regretfully write this letter to inform you that Dr. Elizabeth Liu suddenly and unexpectedly passed away January 3rd, 2021. She leaves behind a legacy of hard work and dedication to her patients and their health. We will miss her dearly. As a patient of Dr. Liu, you are entitled to receive a copy of your health records and find a doctor of your choosing. If you'd like a copy of your health records, please sign and return the HIPAA authorization form attached to this letter and send back via fax at 201-587-8869 or mail to:

Dr. Elizabeth Liu

60 Essex Street Suite 202

Rochelle Park, NJ 07662

Once we receive the signed HIPAA document we can then send the medical records to whoever you choose. Our office remains committed to your health and we are actively trying to bring in a substitute doctor to resume your medical care. Please give us atleast two weeks to do so, and feel free to call us anytime if you have any questions. If you need to find another doctor urgently, you can call your insurance company for a list of providers in your area who accept your insurance. Please know that this loss has affected all of us, and the legacy Dr. Liu left behind will not soon be forgotten. With that being said our office is still here for you and will help you in any way we possibly can.

Regretfully,

Carmen Algarin
Office Manager

Sample HIPAA 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:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT 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 between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

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 your health care providers, 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. § 164.524