

Jennifer Johnson, M.D., MS, FAAP -- Adolescent Medicine Specialist

Diplomate, American Board of Pediatrics and Diplomate, ABP Sub-board in Adolescent Medicine

20+ years helping adolescents achieve optimal health

Authorization to Use, Disclose, and/or Receive Protected Health Information

As required by federal HIPAA Privacy Regulations, Dr. Johnson may not use or disclose your/your child's protected health information (PHI) without your authorization, except as provided in the Notice of Privacy Practices.

Patient name Date of birth Today's date

Address Patient's SSN

If patient is <18 years old, print name of parent/guardian completing/signing form

Check box that applies: Parent Guardian

I authorize Jennifer Johnson, M.D. to use, disclose to, and/or receive health and/or educational information from:

Name and contact information of parent, doctor, health care provider, hospital, and/or other:

Health/education information authorized to be disclosed/received may include any or all of the following:

- Medical records, Discharge summaries, Therapy/counseling records or summaries, Telephone communications, Psychological evaluations, Psychiatric evaluations, School transcripts and records

I furthermore authorize information to be faxed. Patient/parent or guardian initials:

Specific purpose of disclosure:

- All healthcare information, Healthcare information relating to the following treatment, condition, or dates, Other (describe):

Effective dates for this authorization: from Start date (usually today's date) through End date

This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond Dr. Johnson's control. Dr. Johnson will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I understand I have the right to:

- revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
knowledge of any compensation involved due to any marketing activity as allowed by this authorization and as a result of this authorization.
inspect a copy of Patient Health Information being used or disclosed under federal law.
refuse to sign this authorization.
receive a copy of this authorization.
restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my/my child's treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected client health information.

Patient Signature Date Jennifer Johnson, M.D. Date
Patient Parent/Guardian Signature Date Print Parent/Guardian Name