

Drs. Alex and Johnny Johnson  
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**CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE  
AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_, hereby authorize Drs. Alex and Johnny Johnson (hereafter collectively referred to as "Practice") to use and disclose the entire medical record concerning \_\_\_\_\_ in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize Practice to use and disclose verbally, by mail, fax or unencrypted e-mail, the following types of super-confidential information as stated in the NOPP (initial where appropriate):

\_\_\_ HIV records (including HIV test results) and sexually transmissible diseases

\_\_\_ Alcohol and substance abuse diagnosis and treatment records

\_\_\_ Psychotherapy records

**COMPLETE AS APPLICABLE:**

1. Please send a copy of my records (including information from other health-care providers that it may contain) to \_\_\_\_\_ at \_\_\_\_\_. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law.
2. Please allow \_\_\_\_\_ to pick up a copy of my records (including information from other healthcare providers that it may contain). The copies will be ready on \_\_\_\_\_.
3. I acknowledge I will be charged copying costs in the amount of \_\_\_\_\_.

By Patient: \_\_\_\_\_  
(Print name and sign)

Date: \_\_\_\_\_

Patient's: Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

**Or**

By Parent: \_\_\_\_\_  
(Print name and sign)

Date: \_\_\_\_\_

**Or**

By Patient's Representative: \_\_\_\_\_  
(Print name, sign, **and describe authority**)

Date: \_\_\_\_\_