Dr. Alex J. Johnson, DMD, MS

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CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Dr. Alex Johnson and (hereafter
(guardian name if patient is under the age of 18)
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:

Describe the records you wish to access (x-ray, charting, etc.) and the approximate date range if applicable:

_____

Describe what you would like for use to do with your records (check all that apply):

☐ I wish to physically pick up a hard copy of the requested records

☐ I wish for you to mail a hard copy of the records to the following person or health care provider:

_____

☐ If the records are in electronic designated records, I wish to get an electronic copy of the requested records emailed to the following address (please print clearly):

_____@ _____._____

[*I understand there are risks that information in an unencrypted email could be read by a third party. My records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law]*

☐ I acknowledge I will be charged copying costs in the amount of $_____.

By Patient (or legal guardian): _____
(patient or guardian signature)

Patient's DOB: _____ Todays Date: _____