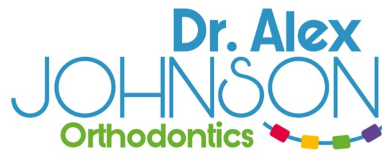
ALEX J. JOHNSON, D.M.D., M.S.

Practice limited to orthodontics



(727) 786-7550

Acknowledgement of Receipt Notice of Privacy Practices (NOPP)
Authorization for Use & Disclosure of Protected Health Information (PHI)

I, ____, hereby authorize
(Guardian Name if Patient is Under Age 18 – or Patient Name)

Dr. Alex J. Johnson (hereafter collectively referred to as "Practice") to disclose related information concerning ______________________________.
(Patient Name)
A copy of this signed, dated Authorization shall be as effective as the original.

The practice may use and disclose the Protected Health Information (PHI) to:

Mother	____________________	**Father**	____________________
Grand Mother	____________________	**Grand Father**	____________________
Nanny	____________________	**Sibling's**	____________________
Spouse	____________________	**Other**	____________________

(Person's to whom we may disclose information in your absence and relationship to you)

For the purpose(s) of (be specific): obtaining information and making appointments in my absence 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 Authorization shall be as effective as the original. I release, hold harmless and agree to indemnify Dr. Alex J. Johnson PA, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Authorization. I specifically authorize Practice to use and disclose verbally, by mail, fax or encrypted e-mail, the following types of super-confidential information as stated in the NOPP **(check where appropriate)**:

☐ Orthodontic Treatment ☐ Progress ☐ Treatment Issues
☐ Make Appointments ☐ Patient Financial Account Information
☐ Insurance Status and/or Payments

Florida law requires your specific authorization to allow any communication of the patient's confidential information with the patient's Authorized Patient Representatives named above.

Signature: ________________________________ ____________________
(Guardian or Patient) (Date)