Donna Johnston, MD

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT PAYMENT OR HEALTH CARE OPERATIONS

- Medical records are to include any and all Federal and State protected information without limitation, to include diagnosis, treatment and/or alcohol and substance abuse, HIV testing/AIDS, pregnancy information and sexually transmitted diseases.

- Dr. Johnston is authorized to use outside vendors for the purpose of copying and providing information requested to carry out treatment, payment, or health care operations. By signing this release, I understand that this authorization will remain in effect until revoked in writing.

- I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf :

Representative:____ Date:_______________

Relationship to Patient:____Date:_______________

- Please review the Notice of Privacy Practices for a more complete description of the potential release and use of such information.

_______I agree and consent to the Practice releasing information to me via regular mail with any envelopes being marked personal and confidential and addressed to me. (I am responsible for notifying the practice of any changes to my address.)

I have read and understand this information in this consent and agree to the above terms.

Signature of Patient: ____Date:_______________

Please print name:____

Witness:____Date:_______________