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Practice limited to pediatric dentistry

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AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I, _____,

(patient name)

hereby authorize Dr. Johnny Johnson & Associates (hereafter collectively referred to as "Practice") to use and disclose in any form or format a copy of records concerning

_____.

(patient name)

A copy of this signed, dated Authorization shall be as effective as the original.

Practice may use and disclose the following information:

To: _____,

(person to whom we may disclose records in your absence)

Relationship to me: _____,

(their relationship to you)

For the purpose(s) of (be specific): obtaining information and copies of my records 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 Practice, 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 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 _____

By Patient: _____

(patient signature)

Date: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION