JOHNSON HEALTH CENTER

HIPAA Consent Form

Patient Name: _____ DOB: _____

Under the requirements of HIPAA we are not allowed to share your health information with anyone without your consent. If you wish to have your medical and billing information discussed with family or friends you must sign this form. Signing this form will only give information to the individuals indicated below.

I, or my authorized individual, allow Johnson Health Center to speak to the following individual(s) regarding my medical or billing information:

1. _____ Relation: _____
   Do you allow the individual(s) listed to schedule appointments on your behalf? __ Yes __ No
   Do you wish to allow us to include substance use information in our disclosure? __ Yes __ No

2. _____ Relation: _____
   Do you allow the individual(s) listed to schedule appointments on your behalf? __ Yes __ No
   Do you wish to allow us to include substance use information in our disclosure? __ Yes __ No

3. _____ Relation: _____
   Do you allow the individual(s) listed to schedule appointments on your behalf? __ Yes __ No
   Do you wish to allow us to include substance use information in our disclosure? __ Yes __ No

4. _____ Relation:_____
   Do you allow the individual(s) listed to schedule appointments on your behalf? __ Yes __ No
   Do you wish to allow us to include substance use information in our disclosure? __ Yes __ No

As the person signing this consent, I understand that **1)** the Disclosing Provider and its employees, agents and volunteers, are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein, and the information may be re-disclosed by the recipient or lose the protections provided by law, **2)** I may revoke my consent at any time, in writing. Unless revoked earlier, this consent will expire one year from the date signed.

_____ _____
(Signature of Person Giving Consent) (Date)

My relationship to the patient is: ___ Self ___ Parent ___ Power of Attorney ___ Legal Guardian

Staff Use:
Identification presented: DL ___ State ID ___ Other _____ Staff Name: _____