

Authorization for Use & Disclosure Of Protected Health Information

Johnson Health Center (JHC) Administrative Offices 134 Elon Rd Madison Heights, VA 24572

Fax: 434-929-2596

DISCLOSE TO (give records out to) GRIAN FROM these records sent to PIO Greeked, JRC will be 'Disclosing Provider' Relation to Patient Greeked, party named below will be 'Disclosing Provider' Greeked, party named below will named below will be 'Disclosing Provider on the 'Disclosing Provider on the extent Indicated and authorized will be 'Disclosing Provider on the extent Indicated and authorized Presing Indicated Provider on the extent Indicated and authorized Presing Provider has an alcohol or drug abuse the subject to the 42 CRK. At the Request of the Changing Physicians and/or Referral Or lose the provider by named by the recipient of tother than as noted in 42 CRK Part 2) or lose the provided by law, 2) I may your party o	Patient Name:		D	OB:	Last 4 o	f Soc Sec#	::	
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(Name of Facility/Person/Designee) (Relation to Patient) (Phone #) (Fax #) (Address – Street, City, State, Zip Code where to mail records) Re following personal health information: (mark all that apply): (Address – Street, City, State, Zip Code where to mail records) Redical Office Notes Statement of Charges and Payments (Ab/X-Ray Results or Images Alcohol/Substance Payments (Ab/X-Ray Results or Images Alcohol/Substance Payments (Achol/Substance Payments) (Dental Records Problem list, med list, immunizations, growth charts (Dental Records Problem list, med list, immunizations, growth charts (Dental Records Problem list, med list, immunizations, growth charts (Dental Records Problem list, med list, immunizations, growth charts (Dental Records Problem list, med list, and list	,			(Pri	nt Name of Person Giving	Consent) , he	reby authorize JHC t	
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Medical Office Notes	(Address – Street, City, St	ate, Zip Code where	to mail records)					
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immunizations, growth charts OTICE: The information approved for disclosure may be protected by Federal Regulations (42 CFR Part 2). The Federal Regulation prohibits a recipient from making a closure of alcohol and substance abuse treatment information without further permission by written consent of the person to whom it pertains or as otherwise permitted tr. 2. This also restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient and limits those who may act on behalf of a pas been declared mentally incompetent by a court and assigned to an individual who has been appointed the patient's legal guardian. 42 CFR permits limited disclosures deaded and the patient's legal guardian. 42 CFR permits limited disclosures declared mentally incompetent by a court and assigned to an individual who has been appointed the patient's legal guardian. 42 CFR permits limited disclosures declared mentally incompetent by a court and assigned to an individual who has been appointed the patient's legal guardian. 42 CFR permits limited disclosures of information declared mentally incompeted by declared as an alcohol or drug abuser is subject to the 42 CFR. Want this information exchanged for the following purpose(s) (check all that apply): At the Request of the Changing Physicians and/or Service Coordination/ Other: Patient or Guardian Continued Treatment Referral To (date)	Lab/X-Ray Results or Images			'				
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the person signing this authorization, I understand that 1) the Disclosing Provider and its employees, agents and volunteers, are not any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein, formation may be re-disclosed by the recipient (other than as noted in 42 CFR Part 2) or lose the protections provided by law, 2) I may reconsent at any time by filling out the Revocation of Authorization to Release Protected Health Information (PHI) Form, except to the at the Disclosing Provider has already taken action on the original request for release of my medical information, 3) If this form is being allow JHC to disclose records to another provider or other third party, I may refuse to sign this form and my signing this authorization of me receiving treatment from JHC, 4) I will be given a copy of this signed consent upon my request. **Ideas revoked earlier*, this Authorization will expire on the following date, event or condition:** **Ideas revoked earlier*, this Authorization will expire on the following date, event or condition:** **Ideas revoked earlier*, this Authorization will expire on the following date, event or condition:** **Ideas revoked earlier*, this Authorization will expire on the following date, event or condition:** **Ideas revoked earlier*, this Authorization will expire on the following date, event or condition:** **Ideas revoked earlier*, this Authorization will expire on the following date, event or condition:** **Ideas revoked earlier*, this Authorization will expire on the following date, event or condition:** **Ideas revoked earlier*, this Authorization will expire on the following date, event or condition:** **Ideas revoked earlier*, this Authorization will expire on the following date, event or condition:** **Ideas revoked earlier*, this Authorization will expire on the following date, event or condition:** **Ideas revoked earlier*, this Authorization will expire on the following date, event or condition:** **I	Patient or Guardi	an Co	ntinued Treatment	Referral				
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