FRANK JOHNSON JR., M.D.
13400 N. MERIDIAN ST., SUITE 600
CARMEL, INDIANA 46032
(317) 582-7430

Authorization for Release of Medical Record Information

I, _____ (name of patient) hereby authorize the office of Frank Johnson Jr., M.D. to release medical record information to third party payers (including, but not limited to insurance companies, their representatives, review organizations, employers, and state and local welfare departments) and health care institutions, physicians, and other providers directly involved in my medical care. I further authorize any other individual or entity that has provided health care to me, which may included hospitals, health care providers, managed care organizations, laboratories, and pharmacies to release to Frank Johnson Jr., M.D., any and all of my medical record information needed to provide me with informed medical care. I understand that my medical record information will be kept confidential pursuant to applicable federal, state, and local laws subject to Frank Johnson Jr., M.D. under applicable law.

I understand that this consent to the release of medical record information may be revoked by me at any time, in writing, by sending such written notification to the office of Frank Johnson Jr., M.D. I understand that a revocation is not effective to the extent that Frank Johnson Jr., M.D. has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protect by federal or state law.

In addition to the above stated, the following person(s) will be authorized to the disclosure of my medical records:

Name:	Relationship:	Phone Number:
_____	_____	_____
_____	_____	_____

Frank Johnson Jr., M.D. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for release of medical record information.

I understand that I have the right to:

- Inspect or copy the protect health information to be used or disclosed as permitted under federal law (or state law to the extent the state provides greater access rights).
- Receive a signed copy of this authorization.

HIPAA

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
ACKNOLWEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Signature:_____Date:_____