Compound Authorization for Release of Information
Dr. Joel Johnson

Full Name of Patient: ______________________________ Date of Birth: __________

The Office Dr. Joel Johnson is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with patient's instructions.

Entity to receive Information Check each person/entity that you approve to receive Information.	**Description of information to be released** Check each that can be given to person/entity on the left in the same section.
[ ] Voice Mail/ Answering Machine	[ ] Appointment Information [ ] Financial Information [ ] Billing Information [ ] Other ______________
[ ] Employer/ School	[ ] Absentee Information (excuse) [ ] Other ______________
[ ] Spouse ______________ [ ] Children ______________ [ ] Parent ______________	[ ] Medical [ ] Appointment Information [ ] Financial Information [ ] Billing Information [ ] Other ______________
[ ] Primary Insurance [ ] Secondary	[ ] Medical/ X-ray as needed [ ] Appointment Information [ ] Billing Information [ ] Other ______________
[ ] Any Referring Dr. [ ] Any Referred Dr.	[ ] Medical/X-ray Information [ ] Appointment Information [ ] Other ______________
[ ] Other	[ ] Appointment Information [ ] Financial Information [ ] Billing Information [ ] Medical Information [ ] Other ______________

Rights of the Patient I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Dr. Joel Johnson at 9 Office Park Court, Columbia SC 29223. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

______________________________ ______________

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority (attach necessary documentation)