



Holcomb Johnston, N.D.
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AUTHORIZATION & REQUEST TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ S.S. #: _____
ADDRESS: _____ D.O.B. _____

AS REQUIRED BY THE PRIVACY REGULATIONS, SWEETGRASS NATURAL MEDICINE MAY NOT USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION EXCEPT AS PROVIDED IN OUR NOTICE OF PRIVACY PRACTICES WITHOUT YOUR AUTHORIZATION.

I HEREBY AUTHORIZE: _____ PHONE#: _____

ADDRESS: _____
STREET CITY STATE ZIP

TO DISCLOSE MY PATIENT HEALTH INFORMATION TO SWEETGRASS NATURAL MEDICINE.

BY INITIALIZING THE SPACES BELOW, I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS:

- | | | |
|---|---|---|
| <input type="checkbox"/> ENTIRE MEDICAL RECORD | <input type="checkbox"/> PROGRESS NOTES | <input type="checkbox"/> LABORATORY REPORTS |
| <input type="checkbox"/> PATHOLOGY REPORTS | <input type="checkbox"/> EKG | <input type="checkbox"/> IMAGING (X-RAY, US, MRI, CT) |
| <input type="checkbox"/> HIV/AIDS RELATED RECORDS | <input type="checkbox"/> DRUG/ALCOHOL RELATED TREATMENT | |
| <input type="checkbox"/> MENTAL HEALTH RECORDS | <input type="checkbox"/> GENETIC TESTING INFORMATION | |
| <input type="checkbox"/> OTHER _____ | | |

FOR THE TIME PERIOD:

PREVIOUS MONTH PREVIOUS _____ MONTHS ENTIRE RECORD

I UNDERSTAND THAT THE INFORMATION DISCLOSED ABOVE MAY BE RE-DISCLOSED TO ADDITIONAL PARTIES AND NO LONGER PROTECTED FOR REASONS BEYOND OUR CONTROL.

I UNDERSTAND I HAVE THE RIGHT TO:

1. REVOKE THIS AUTHORIZATION BY SENDING WRITTEN NOTICE TO THIS OFFICE AND THAT REVOCATION WILL NOT AFFECT THIS OFFICE'S PREVIOUS RELIANCE ON THE USES OR DISCLOSURE PURSUANT TO THIS AUTHORIZATION.
2. KNOWLEDGE OF ANY REMUNERATION INVOLVED DUE TO ANY MARKETING ACTIVITY AS ALLOWED BY THIS AUTHORIZATION, AND AS A RESULT OF THIS AUTHORIZATION.
3. INSPECT A COPY OF PATIENT HEALTH INFORMATION BEING USED OR DISCLOSED UNDER FEDERAL LAW.
4. REFUSE TO SIGN THIS AUTHORIZATION.
5. RECEIVE A COPY OF THIS AUTHORIZATION.
6. RESTRICT WHAT IS DISCLOSED WITH THIS AUTHORIZATION.
7. I ALSO UNDERSTAND THAT IF I DO NOT SIGN THIS DOCUMENT, IT WILL NOT CONDITION MY TREATMENT, PAYMENT, ENROLLMENT IN A HEALTH PLAN, OR ELIGIBILITY FOR BENEFITS WHETHER OR NOT I PROVIDE AUTHORIZATION TO USE OR DISCLOSE PROTECTED PATIENT HEALTH INFORMATION.

SIGNATURE OF PATIENT OR PATIENTS AUTHORIZED REPRESENTATIVE

DATE