**Jason A Johnson, PsyD**
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## Release of Information

This form when completed and signed by you, authorized the designated person or organization to release or obtain protected health information for the following person:

**Name:**_________________________________ **Date of Birth:** __________________________

**SS#**____________________________

**Release of Information**
I authorized ______________________to release the following information verbally or in writing to: ___________________________ for the purposes of __________________________________

_____________________________________________________________________________

Information below has additional laws relating to their use and disclosure. I understand and agree that this information will be disclosed if I place my **initials** below.

_____ HIV/AIDS Information

_____ Substance abuse treatment or diagnosis and Referral Information

_____ Mental health Information

_____ Genetic Testing Information

**This authorization shall remain in effect until** : Expiration date: ____________________

- I understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.
- This authorization shall remain in effect for the duration of my work with Jason A Johnson, PsyD or unless I revoke it in writing.
- To revoke this authorization, please send a written statement to Jason A. Johnson, PsyD, at the current business mailing address and state that you are revoking this authorization. This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance.
- I understand that Jason A. Johnson, PsyD, generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
- I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA privacy rule.

______________________________
**Print** Name of Client or Authorizing Person (parent/guardian) and **Date**: __________

__Jason A. Johnson, PsyD__
Witness and **Date**: ____________

______________________________
**Signature** of Client or Authorizing Person (parent/guardian)

______________________________
**Signature** of Witness