EXHIBIT 6

JOHNSTON FAMILY MEDICINE, LLC

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize **Johnston Family Medicine, LLC** to use and/or disclose certain protected health information (PHI) about me to _____ _____ _____

_____ _____ _____

_____ _____ _____

NAME(S) RELATIONSHIP PHONE NUMBER

This authorization permits **Johnston Family Medicine, LLC** to use and/or disclose the following individually-identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.): _____ or ALL (please circle if no restrictions).

Female Patient: Allow disclosure of all GYN information including pap smear and any culture testing. (please circle)- YES NO

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on_____

{Expiration Date or Defined Event}.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Johnston Family Medicine, LLC**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

41 Magna Way , Suite #100

Westminster MD 21157

Signed by:_____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____ _____

Patient's Name Patient Date of Birth Date

_____

Print Name of Patient or Legal Guardian