HIM ROI Authorization

JOHNS HOPKINS HOSPITALS

Johns Hopkins Hospital
Howard County General Hospital
Sibley Memorial Hospital
Johns Hopkins Bayview Medical Center
Suburban Hospital
Johns Hopkins All Children's Hospital

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Complete all sections of this Authorization as appropriate to your request.

Patient Name: _____ **Birth Date:** _____
(first) (m. initial) (last)

Address: _____ **Phone #:** _____
(street address)

_____ **Medical Record #:** _____
(city) (state) (zip code) (if known)

WHO

I hereby authorize _____ to take the following action.
(Name of the Johns Hopkins Facility or Specific Provider)

ACTION REQUESTED (check one)

☐ Provide a copy of **My Health Information** to me ☐ Let me look at **My Health Information** (I am not requesting a copy)

☐ Release **My Health Information** to: ☐ Discuss **My Health Information** with: ☐ Obtain copies of **My Health Information** from:

_____
(name of other person or entity)

_____ _____
(street address) (city)

_____ _____
(state) (zip code)

WHAT

For this Authorization, **"My Health Information"** means (check one or more):

☐ Abstract (Patient Demographics, Admission information, Discharge Summary, Emergency Department note(s), History and Physical, Consult note(s), Operative Report(s), Procedure Notes, and Results)

☐ Billing Record ☐ Immunization Record ☐ Laboratory Test/Results
☐ Behavioral Health Records ☐ Pathology Test/Results ☐ Imaging Test/Results
☐ Progress Note ☐ ECG Test/Results ☐ Radiology Images (CD or DVD)
☐ Other: _____

If I have initialed here (_____), "My Health Information" includes Substance Abuse Records/Information.

For the date(s) of service from: _____ to _____ (records will be provided for all service dates if left blank)
(insert date(s) of service requested) (Note: Information from recent visits may not yet appear in the record.)

WHY

☐ At my request ☐ For my healthcare / treatment ☐ For legal purposes ☐ For payment / insurance purposes

Other: _____

FORMAT: I request that the copy be provided (where possible/available):

☐ on paper ☐ electronically on CD ☐ electronically on flash drive

☐ by fax to (unable to verify number before faxing): _____

☐ to my MyChart account (Note: Records are retained and stored in various forms, and large volume requests cannot be provided through MyChart.)

☐ through a web portal, with notice provided to my email account at: _____

☐ by unencrypted e-mail to this email address: _____

☐ by other electronic means (if agreed upon by JH records department): _____

Important:

- I understand that if the CD/disc or flash drive is not encrypted or password protected, it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device.
- I understand that unencrypted e-mail is not secure. There is a possibility that information included in an email can be intercepted and/or misaddressed/misdirected and read by other parties besides the person to whom it is addressed. By choosing to receive **My Health Information** on an unencrypted CD/disc, flash drive or by unencrypted e-mail, I am acknowledging and accepting these risks.
- I understand there may be a fee for a copy of **My Health Information**. I understand that all fees will be in compliance with applicable law. I agree to pay this fee.

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid until _____ (not to exceed 1 year in Maryland), unless I revoke/withdraw this Authorization. If no date is included in the blank, this Authorization will expire one year after the date it is signed. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the department or office where my Authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, behavioral health, drug and alcohol abuse, etc.

Signature of Patient Only: _____ **Date**: _____/_____/_____
(Required)

If you are NOT the patient but are signing on behalf of the patient, please complete below.

I, _____, **am the (check which applies)**
(print your name)

☐ **Parent with Parental Rights** *(applies only to minors) (not sufficient for substance abuse records)*
☐ **Informal Kinship Care Relative** *(applies only to minors)* (*Maryland only*) *(not sufficient for substance abuse records)*
☐ **Legal Guardian**
☐ **Patient/Plan Member Appointed Decision Maker** *(e.g., power of attorney) (not sufficient for substance abuse records)*
☐ **Default Substitute Decision Maker** *(e.g., surrogate, proxy) (not sufficient for behavioral health/substance abuse records)*
☐ **Court Appointed Personal Representative of Deceased, Executor or Administrator**

Representative's Signature: _____ **Date**: _____/_____/_____
(Required)

Address: _____ **Phone**: _____

You MUST attach proof of your authority to act on behalf of the patient/plan member as checked above (other than parent).