JOHNS HOPKINS INSTITUTIONS
PSYCHIATRY

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 Johns Hopkins health care 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) (fax number)
(We cannot call before faxing.)

WHAT

For this Authorization, **"My Health Information"** means (check one or more) and may **include** information regarding substance abuse treatment:

☐ Admission History & Physical
☐ Classroom Observation
☐ Diagnostic Test/Results (Lab, X-rays, and other Test Results)
☐ Discharge Summary
☐ Drug & Alcohol Treatment Record
☐ Emergency Room Record
☐ History of Allergies
☐ Immunization Record
☐ Mental Health Records
☐ Operative Report
☐ Outpatient Health Records
☐ Pathology Report
☐ Progress Notes
☐ Psychiatric Admission Note
☐ Psychiatric Evaluation/Diagnoses
☐ Psychological/Educational Report
☐ Psychosocial Assessment

☐ Other: _____

If I have initialed here (_____), this Authorization does NOT include records from other healthcare providers that are a part of my Johns Hopkins records included in this request. (If this blank is not initialed, those records ***will be*** included.)

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

☐ 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 the CD/disc or flash drive is not encrypted or password protected and that it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device. Additionally, I understand that unencrypted e-mail is not secure – that means it could be intercepted and seen by others; in addition, I understand that there are other risks with unencrypted e-mail including misaddressed/misdirected messages; e-mail accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. By choosing to receive **My Health Information** on a CD/disc, flash drive or by unencrypted e-mail, I am acknowledging and accepting these risks.

If Johns Hopkins is to be the recipient of the information, My Health Information received **from** the entity listed above should be directed to the individual named below at the facility that I have checked below:

_____ at _____
[insert therapist/provider] [insert fax number]

or mail to:

☐ Department of Psychiatry
Medical Records
Johns Hopkins Hospital
600 North Wolfe St, Meyer 140
Baltimore, MD 21287

☐ Community Psychiatry Program
Medical Records
Johns Hopkins Bayview Medical Ctr.
4940 Eastern Avenue
Baltimore, MD 21224

☐ Department of Psychiatry
Medical Records
Johns Hopkins Bayview Medical Ctr.
4940 Eastern Avenue
Baltimore, MD 21224

☐ Health Information Management
Howard County General Hospital
5755 Cedar Lane
Columbia, MD 21044

☐ University Mental Health Services
Medical Records
933 North Wolfe Street
Baltimore, MD 21205

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 for one year from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here: _____. 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 clinic or department 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, mental 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** *(not sufficient for substance abuse records)*
- ☐ **Registered Kinship Care Relative** *(not sufficient for substance abuse records)*
- ☐ **Court Appointed Guardian**
- ☐ **Legally Appointed Healthcare Agent** *(not sufficient for substance abuse records)*
- ☐ **Medical Power of Attorney** *(not sufficient for substance abuse records)*
- ☐ **Power of Attorney with Right to See Medical Records** *(not sufficient for substance abuse records)*
- ☐ **Surrogate Decision Maker** *(not sufficient for substance abuse records or mental health records)*
- ☐ **Court Appointed Personal Representative of Deceased**

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

Address: _____ **Phone**: _____

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