EP00002

JOHNS HOPKINS INSTITUTIONS

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)

WHAT

For this Authorization, **"My Health Information"** means (provide description of health information desired):

_____

_____

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 include 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 minor children under 18) (not sufficient for substance abuse records)*
- ☐ **Registered Kinship Care Relative** (*Maryland only*) *(not sufficient for substance abuse records)*
- ☐ **Legal 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 behavioral health records (Maryland or DC) or substance abuse 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).