

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO JOHNS HOPKINS

All items on this authorization must be completed or the request will not be honored. Use "N/A" if not applicable.

For this authorization, "My Health Information" includes _____

(insert description of health information)

In addition, My Health Information **includes** information regarding my **substance abuse** diagnosis and treatment, if any.

I authorize _____ ("Health Care Provider") to provide My Health
Information to _____
(insert name of other health care provider)

Information to _____ for _____
(insert name of other health care provider) (insertion purpose for use or disclosure)

My Health Information should be faxed to _____ **OR** sent to:

(insert street address)

(insert city, state and zip code)

This authorization is valid for one year from date signed, unless I revoke this authorization or unless an earlier date is specified here: _____.

I understand that there is the potential for My Health Information to be re-disclosed and to lose the protection of applicable privacy laws and regulations.

I am not required to sign this authorization. I understand that the Health Care Provider may not condition treatment, payment, benefit eligibility or enrollment activities on the signing of this form. If I do not sign this authorization, my health care provider will not disclose My Health Information to Johns Hopkins. I will receive a copy of this authorization upon signature.

I may revoke this authorization at any time in writing by following the guidelines set forth below.

Patient Name: _____
(first) (m. initial) (last)

Signature: _____ **Date:** _____

Address: _____
(street address)

(city) (state) (zip code)

Phone: _____
(area code) (home phone number)

Medical Record #: _____

Birth Date: _____

For healthcare agent/court appoint guardian/surrogate/parent/informal kinship care relative,
(circle one of the above)

I, _____, **confirm that I am the representative for the patient as circled above.**
(insert your name)

Representative's Signature: _____

Address: _____ **Phone:** _____

If you are the healthcare agent, court appointed guardian or relative providing kinship care, please attach proof of your authority to act on behalf of the patient.

By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization.

I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to the Health Care Provider identified above that provided the health information to Johns Hopkins.

If I am unable to provide a copy of the original authorization with my request to revoke, I will provide the following information.

- Date of the authorization,
- Name,
- Address,
- Phone Number,
- Medical record number,
- Date of birth,
- Purpose of authorization,
- A description of the health information covered by the authorization,
- The person or entity authorized to use the data.

If the form was signed by my representative, the request will also include:

- The representative's name,
- Relationship,
- Address and
- Phone number.

I understand that if I am unable to provide all of the above information, the health care provider may not be able to honor my revocation request.