JOHNS HOPKINS INSTITUTIONS

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION *TO* JOHNS HOPKINS

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)

For this authorization, "**My Health Information**" means:

_____
(provide description of health information)

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

For the date(s) of service from: _____ to _____ (records should be provided for all service dates if left blank)
(insert date(s) of service requested)

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

Health Information to _____ for _____
(insert name of Johns Hopkins person or entity) (insert purpose for use or disclosure)

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

_____
[insert street address]

_____
[insert city, state and zip code]

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- If I do not sign this Authorization, my Health Care Provider will not disclose My Health Information as requested.
- 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 Health Care Provider identified above that provided health information to Johns Hopkins.
- 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, complete the following:

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).