

JOHNS HOPKINS HEALTHCARE LLC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION – UNIQUE/ONETIME REQUEST

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

Plan Member Name: _____
(first) (m. initial) (last)

Address: _____
(street address)

_____ **Phone #:** _____
(city) (state) (zip code)

Birth Date: _____ **Plan Member #:** _____

For this Authorization, "My Health Plan" means: _____
(name of health plan)

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

- Case or Medical Management Record Complete Record (other than substance abuse and mental health, unless initialed below)
 Payment Record Other _____

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)

Unless you initial either statement below, that information will NOT be included in your request.

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

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

For numbers 1 to 4 below, write your initials in the blanks to identify how you want your information to be shared.

1. If I have initialed here (_____), I request to look at My Health Information; I am not asking for a copy.
2. If I have initialed here (_____), I request a copy of My Health Information for myself.
3. If I have initialed here (_____), I authorize My Health Plan to discuss My Health Information with the person or entity identified below on or before _____, 20____ (You must provide the information below if you want this request honored.)
(insert a date)
4. If I have initialed here (_____), I authorize My Health Plan to send a copy of My Health Information to the person or entity identified below either by mail or fax (**Note: we cannot call before faxing.**) (You must provide the information below if you want this request honored.)

For numbers 3 or 4 above, Name of Other Person or Entity: _____

_____ (street address) _____ (city)

_____ (state) _____ (zip code) _____ (fax number)

Reason for request: At my request Other: _____

PLEASE RETURN COMPLETED FORM TO THE ADDRESS OR FAX ON THE SECOND PAGE OF THIS FORM

I understand there may be a charge for copying and handling my request. I understand that all fees will be in compliance with applicable Federal guidelines. By signing this Authorization, I agree to pay these fees at the time this request is made.

I understand that:

- This Authorization is voluntary. Neither the enrollment or eligibility for benefits, nor Payment for my treatment will be impacted, whether I sign this Authorization or not.
- If I do not sign this Authorization, the Plan will not disclose My Health Information as requested.
- I will receive a copy of this Authorization upon signature.
- This Authorization is valid for _____ or until _____: **in absence of any date or time specified, this authorization is valid for six months.**
- 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:

Johns Hopkins HealthCare LLC
6704 Curtis Court
Glen Burnie, MD 21060
Attn: Corporate Compliance Department
Fax: 410 424-4996
Phone: 410 424-4996

- 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 Plan Member Only: _____ Date: ____/____/____

(Required)

If you are NOT the Plan Member but are signing on behalf of the Plan Member, complete the following:

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

- Parent with Parental Rights of Minor Child (*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 Plan Member as checked above (other than parent).