

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. My treatment will not be impacted, no matter if 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 the absence of any date or time specified, this authorization is valid for the duration of my enrollment in the Plan and until all my claims for benefits have been finally resolved.
- 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.
- I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to the Plan at:

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

- 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, _____,
(print your name)

confirm that I am the legally appointed representative for the Plan Member and I have CIRCLED my relationship to the Plan Member below:

- **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 Plan Member as circled above (other than parent).

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