JOHNS HOPKINS HEALTHCARE LLC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION – UNIQUE/ONETIME REQUEST

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

Plan Member Name:	______________________________ (first) (m. initial) (last)
Address:	______________________________ (street address)
	______________________________ (city) (state) (zip code)
Plan Member #:	____________ (if known) **Birth Date:** ____________ **Phone #:** ____________

(Check appropriate check boxes and complete blanks)

For this authorization, "My Health Plan" means ______________________________
(name of health plan)

For this authorization, "My Health Information" means:

☐ Billing Record ☐ Payment Record ☐ Other ____________

☐ Enrollment Record ☐ Case or Medical Management Record

☐ Claims Adjudication Record ☐ Complete Record (other than substance abuse and mental health)

If I have initialed next to the following records, "My Health Information" includes:

_________ Substance Abuse Records ___________ Mental Health Records

☐ for the date(s) of service from: ____________ to: ____________ (otherwise, all periods for which records exist will be provided)
[insert date(s) of service requested]

☐ I request access to look at My Health Information; I am not asking for a copy.

☐ I request a copy of My Health Information.

☐ I authorize My Health Plan to discuss My Health Information with the person or entity identified below if that other person contacts My Health Plan on or before ____________ (specify an outside date), 20_____. (If no date is specified, this request will not be honored.)

☐ I authorize My Health Plan to provide a copy of My Health Information to the person or entity identified below.

State reason for request ______________________________

Name of Other Person or Entity: ______________________________

My Health Information should be ☐ sent ☐ faxed (Note: we cannot call before faxing) to the Other Person or Entity at:

______________________________ (street address) ______________________________ (city)

____________ (State) ____________ (zip code) ____________ (fax number)

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. 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 six months.
- 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).

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