

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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

Patient Name:			
	(first)	(m. initial)	(last)
Address:			
	(street address)		
	(city)	(state)	(zip code)
Medical Record #:	Birth Date: _____		

For this authorization, "My Health Information" means (check all that apply) and may include information regarding substance abuse treatment:

- | | | |
|--|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Diagnostic Test/Results (Lab, X-rays, and other Test Results)/Medications | |
| <input type="checkbox"/> Outpatient Health Records | <input type="checkbox"/> Verbal Communication | <input type="checkbox"/> Psychiatric Evaluation/Diagnoses |
| <input type="checkbox"/> Mental Health Records | <input type="checkbox"/> Drug & Alcohol Treatment Record | <input type="checkbox"/> Psychiatric Admission Note |
| <input type="checkbox"/> Psychosocial Assessment | <input type="checkbox"/> Admission History & Physical | <input type="checkbox"/> Emergency Room Record |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> History of Allergies | <input type="checkbox"/> Psychological/Educational Report | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> Classroom Observation | <input type="checkbox"/> Other: _____ | |

For the date(s) of service starting/ending: _____
[insert dates(s) of service requested]

I authorize Johns Hopkins Hospital's Department of Psychiatry to release My Health Information to receive my information from:

[insert name of person, hospital, agency or program]

[insert street address]

[insert city, state and zip code]

for the following purpose: _____

If Johns Hopkins Hospital is to be the recipient of the information, My Health Information received from the entity listed above should be directed to the Johns Hopkins Hospital's Department of Psychiatry attention:

_____ at _____

[insert therapist/provider] [insert fax number]

or sent to: Department of Psychiatry/Medical Records
 Johns Hopkins Hospital
 600 North Wolfe Street, Meyer 140
 Baltimore, MD 21287-1016

I understand there may be a charge for copying and handling my request. I understand that all fees will be in compliance with applicable Maryland 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, My Health Information will not be disclosed as requested.
- I will receive a copy of this authorization upon signature.
- This authorization is valid for one year from date signed, unless I revoke this authorization or unless an earlier date is specified here: _____. 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.
- 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, _____,
(print your name)

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

- **Parent with Parental Rights**
- **Registered Kinship Care Relative**
- **Medical Power of Attorney**
- **Court Appointed Guardian**
- **Legally Appointed Healthcare Agent**

**Representative's
Signature:** _____

Date: _____

(Required)

Address: _____ **Phone:** _____

You must attach proof of your authority to act on behalf of the patient as circled above (other than parent).