

**JOHNS HOPKINS INSTITUTIONS**

- \_ Johns Hopkins Hospital
- \_ Johns Hopkins Bayview Medical Center
- \_ Howard County General Hospital

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

- **NOT TO BE USED IN CONNECTION WITH HEALTH INFORMATION FROM SUBSTANCE ABUSE TREATMENT OR MENTAL HEALTH PROGRAMS.**

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

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

For this authorization, "My Health Information" means:

<input type="checkbox"/> Abstract (discharge summary, operative notes, clinic notes, diagnostic testing)	<input type="checkbox"/> Discussion with Healthcare Provider
<input type="checkbox"/> Billing Record	<input type="checkbox"/> Outpatient Record
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Diagnostic Test/Results (lab, x-rays and other test results)
<input type="checkbox"/> Mental Health Records	<input type="checkbox"/> Drug & Alcohol Treatment Record
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Admission History & Physical	<input type="checkbox"/> Emergency Room Record
<input type="checkbox"/> Immunization Record	
Other: _____	

For the date(s) of service from: \_\_\_\_\_ to: \_\_\_\_\_  
 [insert date(s) of service requested]

I do  do not  want records received from other healthcare providers that are a part of my Johns Hopkins records included in this request. (If neither box is checked those records will be provided if the request is for all records.)

I authorize \_\_\_\_\_  
 [insert entity]

to provide My Health Information  to me  to another person or entity

\_\_\_\_\_ for \_\_\_\_\_  
 [insert name of other person or entity, if applicable] [insert purpose]

My Health Information should be sent to:

\_\_\_\_\_ [insert contact name at entity, if applicable]

\_\_\_\_\_ [insert street address]

\_\_\_\_\_ [insert city, state and zip code]

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, Johns Hopkins will not disclose My Health Information 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 clinic or department where my authorization was made or given.
- 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
- Court Appointed Guardian
- Legally Appointed Healthcare Agent
- Medical Power of Attorney
- Power of Attorney with Right to See Medical Records
- Surrogate Decision Maker
- 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 circled above (other than parent).**