## JOHNS HOPKINS HOSPITALS

Johns Hopkins Hospital
Howard County General Hospital
Bayview
Suburban Hospital
Sibley Memorial Hospital

HC10079-1

PLACE PATIENT LABEL,HERE

/ /
,
?
/ /

## STANDING AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS

Complete all sections of this Authorization as appropriate for your request.

**Patient Name:**_____ **Birth Date:**_____
(first) (m. Initial) (last)

**Address:** _____ **Phone #:**_____
(street address)

_____ **Medical Record #:**_____
(city) (state) (zip code) (if known)

For this Authorization, **"My Health Care Provider"** means any and all information relating to my course of examination and treatment.

**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**

I authorize My Health Care Provider to discuss my Health Information with the person(s) or entity identified below for general information and inquires, arranging appointments, identifying medications, discussing billing and payment and any other related matter.

Name:_____ Name:_____

Relationship:_____ Relationship:_____

Phone #:_____ Phone #:_____

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 Care Provider will not disclose My Health Information as requested.
- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here:_____. 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 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 disease, mental health, drug and alcohol abuse, etc.

**Signature of Patient Only:**_____ **Date:**_____/_____/_____
(Required)

## JOHNS HOPKINS HOSPITALS

Johns Hopkins Hospital
Howard County General Hospital
Bayview
Suburban Hospital
Sibley Memorial Hospital


HC10079-1

PLACE PATIENT LABEL,HERE

/ /
,
?
/ /

# STANDING AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS

Complete all sections of this Authorization as appropriate for your request.

**If you are NOT the patient but are signing on behalf of the patient, complete the following**

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

- ☐ **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 Record** *(not sufficient for substance abuse records)*
- ☐ **Surrogate Decision Maker** *(not sufficient for substance abuse records or mental healthy 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 patient as checked above (other than parent).**