

EP00002

JOHNS HOPKINS COMMUNITY PHYSICIANS

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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

Patient Name: _				_ Birth Date:	
Address:	(first)	(m. initial)	(last)	Phone #:	
Addicoo.	(sti	reet address)			
-	(city)	(state)	(zip code)	_ Medical Record #:	(if known)
<u>WHO</u>	(),	, ,	· · · /		,
I hereby authoriz	e Johns Hopkins Co m	munity Physicians	to take the follow	ving action.	
•	ESTED (check one)			ŭ	
•	by of My Health Inform a	ation to me	l et me look at N	Ny Health Information (l am not requesting a copy)
	y or my riodini inionii		Lot mo look at i	ny ricular imormation (rum not roquodung a copy)
☐ Release My F	lealth Information to:	☐ Discuss My Hea	Ith Information	with: Obtain copies from:	of My Health Information
				Hom.	
		(name of oth	ner person or entity	<i>y</i>)	
	(street address	8)	 -	(0	ity)
	(state)	(zip o	code)		(fax number) not call before faxing.)
WHAT For this Authoriz	ation, "My Health Infor	mation" means (che	ck one or more):	:	
☐ Abstract (disc	charge summary, operat	ive notes, $\ \square$ Lab F	Reports	☐ Radiology Reports	
clinic notes,	diagnostic testing)	☐ OB/G	YN Reports	Other:	
☐ Billing Record	d	☐ Physi	ical		
☐ Immunization	Record	☐ Prog	ress Notes		
If I have initiale	d here (), "M	y Health Informatior	n" includes Sub	ostance Abuse Records	s/Information.
				ds from other healthcare d, those records <i>will be</i>	providers that are a part of included.)
For the date(s) o	f service from:(in	to sert date(s) of service requ	ested) (recc (Note	ords will be provided for all second will be provided for all second visits	service dates if left blank) may not yet appear in the record.)
<u>WHY</u>					
☐ At my ı	request \square For my he	ealthcare / treatment	☐ For legal	purposes For pay	ment / insurance purposes
Other:					

ORMAT: request:	hat the copy be provided (<u>whe</u> r	e nossible/available).		
on paper	□ electronically o		electronically on flash	drive
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	means (if agreed upon by JH re			
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understand that:				
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