



EP00002

**JOHNS HOPKINS INSTITUTIONS  
PSYCHIATRY**

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

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

**Patient Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
 (first) (m. initial) (last)

**Address:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_  
 (street address)

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

**WHO** JHH Department of Psychiatry and Behavioral Sciences  
 600 N. Wolfe Street, Osler 3-320 Baltimore, MD 21287  
 (O) 443-287-1644 (F) 443-769-1217

I hereby authorize \_\_\_\_\_ to take the following action.

**ACTION REQUESTED (check one)**

Provide a copy of **My Health Information** to me       Let me look at **My Health Information** (I am not requesting a copy)

Release **My Health Information** to:     Discuss **My Health Information** with:     Obtain copies of **My Health Information** from:

\_\_\_\_\_

(name of other person or entity)

\_\_\_\_\_

(street address) (city)

\_\_\_\_\_

(state) (zip code) (fax number)  
 (We cannot call before faxing.)

**WHAT**

For this Authorization, "**My Health Information**" means (check one or more) and may **include** information regarding substance abuse treatment:

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

Other: \_\_\_\_\_

If I have initialed here (\_\_\_\_\_), this Authorization does **NOT** include records from other healthcare providers that are a part of my Johns Hopkins records included in this request. (If this blank is not initialed, those records **will be** included.)

For the date(s) of service from: \_\_\_\_\_ to \_\_\_\_\_ (records will be provided for all service dates if left blank)  
(insert date(s) of service requested) (Note: Information from recent visits may not yet appear in the record.)

**WHY**

At my request     For my healthcare / treatment     For legal purposes     For payment / insurance purposes

Other: \_\_\_\_\_

**FORMAT:** I request that the copy be provided (where possible/available):

Fax to (443) 769-1217  on paper  electronically on CD  electronically on flash drive

through a web portal, with notice provided to my email account at: \_\_\_\_\_

by unencrypted e-mail to this email address: \_\_\_\_\_

by other electronic means (if agreed upon by JH records department): \_\_\_\_\_

**Important:** I understand that the CD/disc or flash drive is not encrypted or password protected and that it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device. Additionally, I understand that unencrypted e-mail is not secure – that means it could be intercepted and seen by others; in addition, I understand that there are other risks with unencrypted e-mail including misaddressed/misdirected messages; e-mail accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. By choosing to receive **My Health Information** on a CD/disc, flash drive or by unencrypted e-mail, I am acknowledging and accepting these risks.

If Johns Hopkins is to be the recipient of the information, My Health Information received **from** the entity listed above should be directed to the individual named below at the facility that I have checked below:

\_\_\_\_\_ at \_\_\_\_\_  
[insert therapist/provider] [insert fax number]

**or mail to:**

Department of Psychiatry  
Johns Hopkins Hospital  
600 North Wolfe St, Osler 320  
Baltimore, MD 21287

Community Psychiatry Program  
Medical Records  
Johns Hopkins Bayview Medical Ctr.  
4940 Eastern Avenue  
Baltimore, MD 21224

Department of Psychiatry  
Medical Records  
Johns Hopkins Bayview Medical Ctr.  
4940 Eastern Avenue  
Baltimore, MD 21224

Health Information Management  
Howard County General Hospital  
5755 Cedar Lane  
Columbia, MD 21044

University Mental Health Services  
Medical Records  
933 North Wolfe Street  
Baltimore, MD 21205

I understand there may be a fee for a copy of My Health Information. I understand that all fees will be in compliance with applicable law. I agree to pay this fee.

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- 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 diseases, mental health, drug and alcohol abuse, etc.

**Signature of Patient Only:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Required)

**SIGN HERE**

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

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 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 patient as checked above (other than parent).**