JOHNS HOPKINS OCCUPATIONAL HEALTH

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION OF JOHNS HOPKINS WORKFORCE MEMBER (INCLUDING AGENCY STAFF) BY JOHNS HOPKINS

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

Employee Name: _____ **Birth Date:** _____
(first) (m. initial) (last)

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

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

For this authorization, "My Health Information" means all of my health information held in my Johns Hopkins Occupational Health medical records and includes, but is not limited to, my name, address, other contact information, date of birth, age, gender, tests performed (including drug screens), test results, inability or ability to work, work limitations, rehabilitation information, medical complaints related to exposure to hazardous substances and diagnosis.

I authorize Johns Hopkins to disclose My Health Information to my current Johns Hopkins employer, to Johns Hopkins affiliates for safety and job related purposes, to my current agency staff employer, and/or to the Johns Hopkins employer to which I am applying (for example, to the supervisor, Human Resources representatives, medical review officer and legal counsel). I further authorize Johns Hopkins to disclose My Health Information in any and all employment related proceedings (including, but not limited to, workers compensation claims, unemployment insurance proceedings and/or other local, State or federal regulatory agency complaint proceedings arising during or after my employment

This authorization is valid for the duration of my employment and thereafter for matters relating to my employment.

Signature of Employee Only: _____ **Date**:_____
(Required)

If you are NOT the employee but are signing on behalf of the employee, complete the following:

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

- **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**

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).

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not request or provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sough t or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.