JOHNS HOPKINS OCCUPATIONAL HEALTH

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION

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

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, health questionnaire or history, 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 employer, Johns Hopkins affiliates for safety and job related purposes, my agency staff employer, and/or the medical staff office or Johns Hopkins employer where I am or where I am applying to be credentialed or employed:

_____
[insert company name]

(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 one year, unless I revoke this authorization, or unless an earlier date is specified here: _____.

I may revoke this authorization at any time in writing by mailing or faxing my written request, along with a copy of this authorization if possible, to the location where I obtained my employment related physical. My revocation will not affect any disclosures that occurred prior to the location receiving my revocation.

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

If you are NOT the patient but are signing on behalf of the patient, 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).