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**

I hereby authorize _____ to take the following action.
(name of Johns Hopkins health care provider)

**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)

**WHAT**

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

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

☐ Other: _____

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):

☐ on paper ☐ electronically on CD ☐ electronically on flash drive

☐ by fax to (unable to verify number before faxing): _____

☐ to my MyChart account (Note: Records are retained and stored in various forms, and large volume requests cannot be provided through MyChart.)

☐ 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 if the CD/disc or flash drive is not encrypted or password protected, it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device.
- I understand that unencrypted e-mail is not secure. There is a possibility that information included in an email can be intercepted and/or misaddressed/misdirected and read by other parties besides the person to whom it is addressed. By choosing to receive **My Health Information** on an unencrypted CD/disc, flash drive or by unencrypted e-mail, I am acknowledging and accepting these risks.
- 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.

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
Medical Records
Johns Hopkins Hospital
600 North Wolfe St, Meyer 140
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 that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid until _____ (not to exceed 1 year in Maryland), unless I revoke/withdraw this Authorization. If no date is included in the blank, this Authorization will expire one year after the date it is signed. 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 department or office 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, behavioral health, drug and alcohol abuse, etc.

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

**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** *(applies only to minors) (not sufficient for substance abuse records)*
☐ **Informal Kinship Care Relative** *(applies only to minors)* (*Maryland only*) *(not sufficient for substance abuse records)*
☐ **Legal Guardian**
☐ **Patient/Plan Member Appointed Decision Maker** *(e.g., power of attorney) (not sufficient for substance abuse records)*
☐ **Default Substitute Decision Maker** *(e.g., surrogate, proxy) (not sufficient for behavioral health/substance abuse records)*
☐ **Court Appointed Personal Representative of Deceased, Executor or Administrator**

**Representative's Signature**: _____ **Date**: _____/_____/_____
(Required)

**Address**: _____ **Phone**: _____

**You MUST attach proof of your authority to act on behalf of the patient/plan member as checked above (other than parent).**