

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION – SPECIFIC REQUEST**

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

**Plan Member:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
**Name** (first) (m. initial) (last)  
**Address:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_  
(street address)  
\_\_\_\_\_ **Plan Member #:** \_\_\_\_\_  
(city) (state) (zip code) (if known)

**WHO**

I hereby authorize \_\_\_\_\_ to take the following action. (fill in above the name of the health plan)

**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):

- Case or Medical Management Record       Complete Record  
 Payment Record      (other than substance abuse and mental health, unless initialed below)

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.)

***Unless you initial either statement below, that information will NOT be included in your request.***

If I have initialed here (\_\_\_\_\_), "My Health Information" includes Substance Abuse Records/Information.

If I have initialed here (\_\_\_\_\_), "My Health Information" includes Mental Health Records/Information.

**WHY**

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

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

**PLEASE RETURN COMPLETED FORM TO THE ADDRESS OR FAX ON THE SECOND PAGE OF THIS FORM**

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

- 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.

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. Neither the enrollment or eligibility for benefits, nor payment for my treatment, will be impacted, whether I sign this Authorization or not.
- This Authorization is valid for \_\_\_\_\_ or until \_\_\_\_\_; **in absence of any date or time specified, this authorization is valid for six months.**
- 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:

Johns Hopkins HealthCare LLC  
6704 Curtis Court  
Glen Burnie, MD 21060  
Attn: Corporate Compliance Department  
Fax: 410 762-1527  
Phone: 410 424-4996

- 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 Plan Member Only:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Required)

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

I, \_\_\_\_\_, am the (check 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
- Surrogate Decision Maker
- 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 Plan Member as checked above (other than parent).**