JOHNS HOPKINS HEALTHCARE LLC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION – SPECIFIC REQUEST

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

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

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

_____ (city) (state) (zip code) **Plan Member #:** _____ (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

☐ Payment Record

☐ Complete 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

☐ 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
  7231 Parkway Drive, Suite 100
  Hanover, MD 21076
  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** *(not sufficient for substance abuse records)*
- ☐ **Registered Kinship Care Relative** (*MD only*) *(not sufficient for substance abuse records)*
- ☐ **Legal 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 mental health records (MD or DC) or substance abuse 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).