JOHNS HOPKINS HEALTHCARE LLC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION – STANDING

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

Plan Member Name: _____ **Birth Date:** _____
(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

To discuss **My Health Information** with:

_____
(name of other person or entity)

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 _____
(insert date(s) of service requested)

Unless you initial either statement below, that information will <u>NOT</u> 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

For general information and inquiries, assistance in processing my claims for benefits, and for

_____
(insert additional purpose if any)

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

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 the duration of my enrollment in the Plan and until all my claims for benefits have been fully resolved.**
- 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 plan member as checked above (other than parent).