AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO JOHNS HOPKINS

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

Patient Name:	_____ (first) (m. initial) (last)
Address:	_____ (street address)
	_____ (city) (state) (zip code)
Birth Date:	_____

For this authorization, "My Health Information" means _____

_____.

[insert description of health information]

In addition, My Health Information **includes** information regarding my **substance abuse** diagnosis and treatment, if any.

I authorize _____ ("Health Care Provider") to provide My Health
[insert name of other health care provider]

Information to _____ for _____
[insert name of Johns Hopkins person or entity] [insert purpose for use or disclosure]

_____.

My Health Information should be faxed to _____ **OR** sent to:

_____
[insert street address]

_____
[insert city, state and zip code]

I understand that:

- This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not.
- If I do not sign this authorization, My Health Care Provider will not disclose My Health Information to Johns Hopkins.
- I will receive a copy of this authorization upon signature.
- This authorization is valid for one year from the date signed, unless I revoke this authorization or unless an earlier date is specified here: _____. I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to the Health Care Provider identified above that provided the health information to Johns Hopkins.
- 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 Patient only: _____ **Date:** _____

(Required)

If you are NOT the patient but are signing on behalf of the patient complete the following:

I, _____**,**

(print your name)

confirm that I am the legally appointed representative for the patient and I have CIRCLED my relationship to the patient below:

- **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 patient as circled above (other than parent).

PLEASE FAX THIS COMPLETED REQUEST TO:
BAYVIEW MEDICAL RECORDS
410-550-3409

Or mail to:

Johns Hopkins Bayview Medical Center
Medical Records Department, A Building-Ground Floor
4940 Eastern Avenue
Baltimore, Maryland 21224