JOHNS HOPKINS INSTITUTIONS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO THIRD PARTIES

- **NOT TO BE USED TO RELEASE PATIENT'S OWN RECORDS TO PATIENT (USE HIPAA FORM A.6.2) OR FOR BILLING RECORDS (USE HIPAA FORM A.2.1.w).**
- **NOT TO BE USED IN CONNECTION WITH HEALTH INFORMATION FROM SUBSTANCE ABUSE TREATMENT PROGRAMS.**
- **AN AUTHORIZATION MAY NOT BE USED TO GRANT DIRECT ACCESS TO ANY ELECTRONIC PATIENT RECORD.**

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

For this authorization, "My Health Information" is:

_X__ Complete Record (other than billing)

Other:

For the date(s) of service starting: BIRTH TO PRESENT

I authorize _____ _____
[insert entity]
to disclose My Health Information to _____GRETCHEN OSWALD, MS CGC_____ for

My Health Information should be faxed to **410-614-9246** **OR** sent to:

GRETCHEN OSWALD
JOHNS HOPKINS HOSPITAL
BLALOCK 1008
600N. WOLFE STREET
BALTIMORE, MD 21287

I understand there is a charge for copying and handling my request. I understand that all fees will be in compliance with applicable Maryland State guidelines. By signing this authorization, I agree to pay these fees at the time this request is made.

This authorization is valid for one year from date signed, unless I revoke this authorization, or unless an earlier date is specified here: _____.

I understand that once My Health Information is disclosed as requested in this authorization My Health Information may no longer be protected by federal and state privacy laws and potentially may be re-disclosed by the person who is receiving my information.

I am not required to sign this authorization. Johns Hopkins does not condition treatment, payment, benefit eligibility or enrollment activities on the signing of this form. If I do not sign this authorization, Johns Hopkins will not disclose My Health Information as requested. I will receive a copy of this authorization upon signature.

I may revoke this authorization at any time in writing by following the guidelines set forth below.

Patient Name: _____
(first) (m. initial) (last)

Signature: _____ **Date:** _____

Address: _____
(street address)

_____
(city) (state) (zip code)

Phone: _____
(area code) (home phone number)

Medical Record #: _____

Birth Date: _____

For healthcare agent/court appointed guardian/surrogate/parent/informal kinship care relative or Personal Representative of the deceased,
(circle one of the above)

I, _____ confirm that I am the representative for the patient as circled above.
(insert your name)

Representative's Signature: _____

Address: _____ **Phone:** _____

If you are the healthcare agent, court appointed guardian, relative providing informal kinship care or court appointed Personal Representative of the deceased, please attach proof of your authority to act on behalf of the patient.

By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization.

I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to the clinic or department where my authorization was made or to:

Johns Hopkins Privacy Officer
5801 Smith Avenue
McAuley Hall, Suite 310
Baltimore, MD 21209
Fax 410-735-6521

If I am unable to provide a copy of the original authorization with my request to revoke, I will provide the following information.

- Date of the authorization,
- Name,
- Address,
- Phone number,
- Medical record number,
- Date of birth,
- Purpose of authorization,
- A description of the health information covered by the authorization,
- The person or entity authorized to use the data.

If the form was signed by my representative, the request will also include:

- The representative's name,
- Relationship,
- Address and
- Phone number.

I understand that if I am unable to provide all of the above information, Johns Hopkins may not be able to honor my revocation request.