JOHNS HOPKINS UNIVERSITY | Student Health & Well-Being
Mental Health Services

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Client Name: _____ **Client Phone #:** _____

Client DOB: _____

Client Address:

_____
(street) (city) (state) (zip)

I, _____**, hereby authorize the staff of**
(client or other authorized person completing this form)

Johns Hopkins University Student Health and Well-Being Mental Health Services

☐ **to exchange information with** ☐ **to disclose information to** ☐ **receive information from**

Contact Person(s) and/or Agency Name: WellFleet Student Insurance

The information to be disclosed is:
- ☐ Attendance information
- ☐ Summary of treatment
- ☐ All treatment records
- ☐ Withdrawal/Readmission recommendation
- [X] Other (specify): Referral to community mental health provider

The purpose of this disclosure is for:
- ☐ Coordination of care/referral
- ☐ Withdrawal/Readmission process
- [X] Other (specify): Reduction of insurance deductible

This consent is effective on _____ **and expires on** August 24, 2024.
(today's date) (no greater than 1 year from today's date)

I understand that I may revoke this consent at any time within the effective period by written request.

Client/Authorized Person Signature: _____ **Therapist Name:** _____

NOTICE*: This information has been disclosed from confidential records. Any further disclosure without the specific written consent of the person to whom it pertains is prohibited, except as provided by law. For example, should a counselor be legally and/or ethically required to take responsible action, including, but not limited to, where there is danger of imminent harm to self or others, or in the case of apparent child abuse, information included in confidential records may be further disclosed without specific written consent as prescribed by law.*