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

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR ADD/ADHD CONTINUITY OF CARE

The student/learner below is requesting to transfer management of ADD/ADHD medicines during the academic year to Johns Hopkins University Student Health and Well-Being Mental Health and/or Primary Care Services. All fields are required with complete information to facilitate transfer of care.

Client Name:_____ Client Phone #:_____

Client Date of Birth: ____/____/_____

Client Address:

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

I, _____, hereby authorize the release of information from the provider or agency below to facilitate the transfer of my care to Johns Hopkins University Student Health and Well-Being Mental Health and/or Primary Care Services. In addition to the information contained on this form, **I authorize the release of my treatment record including clinical interview notes, testing and assessment reports and/or completed self-report measures, and medication history.** I also authorize the exchange of information between the Provider/Agency and Johns Hopkins University Student Health and Well-Being Mental Health and/or Primary Care Services for the purposes of care coordination.

Provider/Agency Name:_____

Provider/Agency Phone # :_____ Provider/Agency Fax # :_____

Provider/Agency Address:

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

This consent is effective on _____ and expires on _____.
(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 signature: _____ Date: _____

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.*

TO BE COMPLETED BY PROVIDER

Date of clinical evaluation for ADHD: _____ ICD-10 diagnosis code(s): _____

Relevant history and supporting information for diagnosis of ADD/ADHD:

Please provide copies of records or any administered tests (including self-report forms, semi-structured interviews, etc.) that were used for evaluation and diagnosis.

List medications prescribed in treatment of ADHD, including name of medicine, dose strength and schedule, as well as notes related to response or adverse effects:

Date, dose, and quantity of last stimulant prescription:

Any additional diagnoses or treatment provided:

_____

Provider Signature

_____

Provider Name (please print) **Date**

Please fax completed form and all attachments to Johns Hopkins University Student Health & Well-Being Mental Health

and/or Primary Care Services at _____.
(requesting provider name) (requesting provider fax #)

For questions, please contact the clinic at _____.