JOHNS HOPKINS UNIVERSITY

Student Health and Well-Being
Primary Care

Patient label

Homewood Location	East Baltimore Location	Washington, DC Location
1 East 31st Street, N200	933 North Wolfe Street	555 Pennsylvania Avenue, NW, Suite 554
Baltimore, MD 21218	Baltimore, MD 21205	Washington, DC 20001
P: 410-516-8270	P: 410-955-3250	P: 202-249-7333
F: 410-516-4784	F: 410-614-3643	

Authorization for Release of Health Information

Student/Patient Full Name_____

Address_____

Date of Birth_____/____/_____ Phone Number _____

Last Year Attended _____

WHO

I hereby authorize the JHU Student Health and Well-Being Primary Care to take the following action.

ACTION REQUESTED (check one)

☐ Provide a copy of **My Health Information** to me ☐ Let me look at **My Health Information** (I am not requesting a copy)

☐ Release **My Health Information** to: ☐ Discuss **My Health Information** with: ☐ Obtain copies of **My Health Information** from:

_____
(name of other person or entity)

_____ _____
(street address) (city)

_____ _____
(state) (zip code)

WHAT

For this Authorization, "**My Health Information**" means (check one or more):

☐ All of my medical records and information*, **EXCEPT** medical records and information regarding:
- ☐ Behavioral health
- ☐ Reproductive health, including information about contraception
- ☐ Sexually transmitted infections, including HIV and AIDS
- ☐ Drug and alcohol use
- ☐ Other (*please specify*) _____

OR

☐ All of my medical records and information* OR

☐ ONLY Immunization information AND/OR

☐ ONLY information about my appointments and whether I have been to or am in the Student Health and Well-Being Primary Care AND/OR

☐ Other (*please specify*) _____

For the date(s) of service from: _____ to _____ (records will be provided for all service dates if left blank.)
insert date(s) of service requested) (Note: Information from recent visits may not yet appear in the record.)

* Note that this Authorization does not include psychotherapy notes created by JHU Mental Health Services. A separate consent is required to release psychotherapy notes from JHU Mental Health Services. However, my medical records may include some behavioral health information related to any visits to or treatment I may receive from JHU Mental Health Services (i.e., diagnosis, medications, etc.).

WHY

☐ Keeping my parents informed of my medical and health care and treatment and health status

☐ At my request ☐ For my healthcare / treatment ☐ For legal purposes ☐ For payment / insurance purposes

Other: _____

FORMAT: I request that the copy be provided (where possible/available):

☐ on paper ☐ electronically on flash drive

☐ by fax to (unable to verify number before faxing): _____

☐ by unencrypted e-mail to this email address: _____

☐ by other electronic means (if agreed upon by JH records department): _____

Important:

- I understand that if the CD/disc or flash drive is not encrypted or password protected, it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device.
- I understand that unencrypted e-mail is not secure. There is a possibility that information included in an email can be intercepted and/or misaddressed/misdirected and read by other parties besides the person to whom it is addressed. By choosing to receive **My Health Information** on an unencrypted CD/disc, flash drive or by unencrypted e-mail, I am acknowledging and accepting these risks.
- I understand there may be a fee for a copy of **My Health Information**. I understand that all fees will be in compliance with applicable law. I agree to pay this fee.

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid until _____ (not to exceed 1 year in Maryland), unless I revoke/withdraw this Authorization. If no date is included in the blank, this Authorization will expire one year after the date it is signed. 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 the department or office where my Authorization was made or given.
- 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, behavioral health, drug and alcohol abuse, etc.

Signature of Student/Patient Only: _____ **Date**: _____/_____/_____
(Required)

If you are NOT the patient but are signing on behalf of the patient, please complete below.

I, _____, **am the (check which applies)**
(print your name)

☐ **Parent with Parental Rights** ***(****applies only to minors) (not sufficient for substance abuse records)*
☐ **Informal Kinship Care Relative** *(applies only to minors)* (*Maryland only*) *(not sufficient for substance abuse records)*
☐ **Legal Guardian**
☐ **Patient/Plan Member Appointed Decision Maker** *(e.g., power of attorney) (not sufficient for substance abuse records)*
☐ **Default Substitute Decision Maker** *(e.g., surrogate, proxy) (not sufficient for behavioral health/substance abuse records)*
☐ **Court Appointed Personal Representative of Deceased, Executor or Administrator**

Representative's Signature: _____ **Date**: _____/_____/_____
(Required)

Address: _____ **Phone**: _____

You MUST attach proof of your authority to act on behalf of the patient/plan member as checked above (other than parent).