THE JOHNS HOPKINS UNIVERSITY
STUDENT HEALTH AND WELL-BEING PRIMARY CARE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO JOHNS HOPKINS

Complete all sections of this Authorization as appropriate to your request.

Patient Name: _____ **Birth Date:** _____
(first) (m. initial) (last)

Address: _____ **Phone #:** _____
(street address)

_____ **Medical Record #:** _____
(city) (state) (zip code) (if known)

School Enrolled: _____ **Status:** ____ **U/G** ____ **Grad** ___ **PD**

For this Authorization, "**My Health Information**" means: _____

_____
(insert description of health information)

If I have initialed here (_____), "My Health Information" includes Substance Abuse Records/Information.

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)

I authorize _____["Health Care Provider"]
[insert name of other health care provider]

to provide **My Health Information** to the JHU Student Health & Well-Being Primary Care for
_____
[insert purpose]

My Health Information should be faxed or sent to the following Student Health and Well-Being Primary Care location:

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

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, the Health Care Provider will not disclose My Health Information as requested.
- 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 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).