JOHNS HOPKINS UNIVERSITY
Student Health and Well-Being
Primary Care

Homewood Location	East Baltimore Location	Washington, DC Location
1 East 31st St, N200	933 North Wolfe St	555 Pennsylvania Ave, NW, Suite 554
Baltimore, MD 21218	Baltimore, MD 21205	Washington, DC 20001
P: 410-516-8270	P: 410-516-8270	P: 410-516-8270
F: 410-516-4784	F: 410-614-3643	F: 443-769-1262

Patient label

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 Wellness Center 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) (fax number)
(We cannot call before faxing.)

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:
- ☐ Mental 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 Wellness Center AND/OR

☐ Other (*please specify*)

If I have initialed here (_____), this Authorization does NOT include records from other healthcare providers that are a part of my Johns Hopkins records included in this request. (If this blank is not initialed, those records *will be* included.)

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 the JHU Counseling Center. A separate consent is required to release psychotherapy notes from the JHU Counseling Center. However, my medical records may include some mental health information related to any visits to or treatment I may receive from the Counseling Center (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 unencrypted e-mail to this email address: ☐ by other electronic means (if agreed upon by JH records department):

_____

Important: I understand that the CD/disc or flash drive is not encrypted or password protected and that it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device. Additionally, I understand that unencrypted e-mail is not secure – that means it could be intercepted and seen by others; in addition, I understand that there are other risks with unencrypted e-mail including misaddressed/misdirected messages; e-mail accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. By choosing to receive My Health Information on a 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 for one year from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here: _____. 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 clinic or department 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, mental 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 *(not sufficient for substance abuse records)*

☐ Registered Kinship Care Relative Court Appointed *(not sufficient for substance abuse records)*

☐ Guardian Legally Appointed Healthcare Agent *(not sufficient for substance abuse records)*

☐ Medical Power of Attorney *(not sufficient for substance abuse records)* Power of Attorney with Right to See Medical Records *(not sufficient for substance abuse records)*

☐ Surrogate Decision Maker *(not sufficient for substance abuse records or mental health records)*

☐ Court Appointed Personal Representative of Deceased

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

Address: _____ Phone: _____