JOHNS HOPKINS UNIVERSITY

Student Health and Well-Being
Clinical Services
P: 410-516-3311
F: 877-685-6925

Patient label

Authorization for Release of Health Information

Student/Patient Full Name_____

Address_____

Date of Birth _____/_____/_____ Phone Number _____

WHO

I hereby authorize the JHU Student Health and Well-Being Clinical Services 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
- ☐ All Primary Care records
- ☐ Immunization information
- ☐ Billing records
- ☐ Reproductive health, including information about contraception
- ☐ Sexually transmitted infections, including HIV and AIDS
- ☐ All Mental Health records
- ☐ Substance abuse records/information
- ☐ Dates of appointments/confirmation of attendance
- ☐ Recommendation for Medical Leave of Absence and/or reinstatement process
- ☐ Other (*please specify*) _____

For the date(s) of service from: _____ to _____ (records will be provided for past 5 years unless otherwise specified)
insert date(s) of service requested) (**Note:** Information from recent visits may not yet appear in the record.)

WHY

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

☐ For payment / insurance purposes ☐ For a medical leave of absence and/or reinstatement process

Other: _____

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

☐ on paper

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

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

☐ to my MyHealth portal: _____

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

Important:

- 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** 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 of a minor with parental rights as noted above).