**JOHNS HOPKINS INSTITUTIONS**

For addressograph plate

- Johns Hopkins Hospital
- Johns Hopkins Bayview Medical Center
- Howard County General Hospital

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**NOT TO BE USED IN CONNECTION WITH HEALTH INFORMATION FROM SUBSTANCE ABUSE TREATMENT OR MENTAL HEALTH PROGRAMS.**

All items on this authorization must be completed or the request will not be honored. Use "N/A" if not applicable.

| | |
|---|---|
| **Patient Name:** | (first) (m. initial) (last) |
| **Address:** | (street address) |
| | (city) (state) (zip code) |
| **Medical Record #:** | **Birth Date:** |

For this authorization, "My Health Information" means:

| | |
|---|---|
| _____ Abstract (discharge summary, operative notes, clinic notes,diagnostic center) | |
| _____ Billing Record | _____ Discussion with Healthcare Provider |
| _____ Discharge Summary | _____ Outpatient Record |
| _____ Mental Health Records | _____ Discussion Test/Results (lab, x-rays and other test results) |
| _____ Operative Report | _____ Drug & Alcohol Treatment Record |
| _____ Admission History & Physical | _____ Pathology Report |
| _____ Immunization Record | _____ Emergency Room Record |

[✓] Other: PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

For the dates(s) of service from: _____ (insert date(s) of service requested) to: _____ (insert date(s) of service requested)

I do ☐ do not ☐ want records received from other healthcare providers that are a part of my Johns Hopkins records included in this request. (if neither box is checked, those records will be provided if the request is for all records.)

I authorize **JOHNS HOPKINS INSTITUTIONS** (insert entity)

to provide My Health Information ☐ to me ☒ to another person or entity

RECORDS DEPOSITION SERVICE, INC. (insert name of other person or entity, if applicable) for LEGAL - DISCOVERY BEFORE TRIAL (insert purpose)

My Health Information should be sent to:

_____ (insert contact name at entity, if applicable)

P.O. BOX 5054 P: 248-357-3330

(insert street address)

SOUTHFIELD, MI 48086-5054 F: 248-357-3337

(insert city, state and zip code)

I understand there may be a charge for copying and handling my request. I understand that all fees will be in compliance with applicable Maryland guidelines. By signing this authorization, I agree to pay these fees at the time this request is made.

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, Johns Hopkins will not disclose My Health Information as requested.
- I will receive a copy of this authorization upon signature.
- This authorization is valid for one year from date signed, unless I revoke this authorization or unless an earlier date is specified here: _____. I may revoke this authorization 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 Patient only:** _____ **Date:** _____
(Required)

**If you are NOT the patient but you are signing on behalf of the patient complete the following:**

I, _____,
(print your name)

**confirm that I am the legally appointed representative for the patient and I have CIRCLED my relationship to the patient below:**

- **Parent with Parental Rights**
- **Registered Kinship Care Relative**
- **Court Appointed Guardian**
- **Legally Appointed Healthcare Agent**
- **Medical Power of Attorney**
- **Power of Attorney with Right to See Medical Records**
- **Surrogate Decision Maker**
- **Court Appointed Personal Representative of Deceased**

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

**Address:** _____ **Phone:** _____

**You must attach proof of your authority to act on behalf of the patient as circle above (other than parent).**