The Alan Mason Chesney Medical Archives
of the Johns Hopkins Medical Institutions
5801 Smith Avenue, Suite 235, Baltimore MD 21209
410-735-6800, Fax 410-735-6770

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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

Subject Name: _ _____ _____ _____ **Birth Date**: _____
(first) (m. initial) (last) *(if alive)*

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

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

Other Identifying Information_ _____

_____

WHO

For this Authorization, The Alan Mason Chesney Medical Archives is referred to as the "Archives."

I hereby authorize the Archives 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 the person or entity named below
- ☐ Discuss **My Health Information** with the person or entity named below

_____
(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 (*provide description of health information desired*):

_____
_____

If I have initialed here (_____), "My Health Information" includes all medical records relating to the Subject held by or transferred to the Archives, including but not limited to illustrations, photographs and other imaging records.

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

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 (*records will be provided for all service dates if left blank*):

From: _____ to _____
(insert date(s) of service requested)

WHY

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

☐ Other: _____

☐ For purposes of research described briefly as follows: _____

_____

If this line is initialed, _____I grant permission for publication of the Health Information as follows:

_____

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

☐ on paper ☐ electronically on CD ☐ electronically on flash drive

☐ through a web portal, with notice provided to my email address:

Web address: _____ Email address: _____

☐ 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. If I am requesting access to My Health Information for my own purposes, I agree to pay this fee. If I am authorizing release for research, I understand that the fee will be paid by the researcher.

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 Subject Only: _____ **Date**: _____/_____/_____
(Required)

If you are NOT the subject but are signing on behalf of the subject, 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** *(not sufficient for substance abuse records)*
- ☐ **Court Appointed 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**

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

If Subject is deceased and you are not the Court Appointed Personal Representative of Deceased, please complete below:

☐ **To the best of my knowledge, no personal representative, administrator or executor has been appointed or is still in effect for the estate of the Subject.**

☐ **I affirmatively believe that I am the appropriate person to make decisions about the Health Information of the Subject. Please describe your relationship to the deceased subject:**

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

Address: _____

Phone:_____ **E-mail:** _____