JHH PSYCHIATRY

AUTHORIZATION FOR RELEASE OF INFORMATION TO THIRD PARTIES

- **NOT TO BE USED TO RELEASE PATIENT'S OWN RECORDS TO PATIENT (USE HIPAA FORM A.6.2) OR FOR BILLING RECORDS (USE HIPAA FORM A.2.1.w).**
- **AN AUTHORIZATION MAY NOT BE USED TO GRANT DIRECT ACCESS TO ANY ELECTRONIC PATIENT RECORD.**

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

For this authorization, "My Health Information" means (check all that apply) and may include information regarding substance abuse treatment:

□ Complete Record (All)	☑ **Diagnostic Test/Results (Lab, X-rays, and other Test Results) /Medications)**	
☑ **Discharge Summary**	☑ **Verbal Communication**	☑ **Psychiatric Evaluation/Diagnoses**
□ Outpatient Health Records	☑ **Drug & Alcohol Treatment Record**	☑ **Psychiatric Admission Note**
☑ **Mental Health Records**	□ Admission History & Physical	□ Emergency Room Record
□ Psychosocial Assessment	□ Operative Report	□ Pathology Report
□ Progress Notes	□ Psychological/Educational Report	□ Immunization Record
□ History of Allergies	□ Classroom Observation	□ Other:

For the date(s) of service starting/ending: _____

[insert date(s) of service requested]

I authorize Johns Hopkins Affective Disorders Consultation Clinic
to _____ release My Health Information to / ____✓____ receive My Health Information from:

_____
[insert name of person, hospital, agency or program]

_____
[insert street address]

_____
[insert city, state and zip code]

for the following purpose: **pyschiatric evaluation/diagnosis**.

If Johns Hopkins is to be the recipient of the information, My Health Information received from the entity listed above should be directed to the Johns Hopkins Affective Disorders Clinic, attention:

Affective Disorders Consultation Clinic at (410) 955-0152

or sent to mailing address: Affective Disorders Consultation Clinic
Johns Hopkins Hospital
600 North Wolfe Street, Meyer 3-181
Baltimore, MD 21287-7381

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

This authorization is valid for one year from date signed, unless I revoke this authorization, or unless an earlier date is specified here: _____.

I understand that once My Health Information is disclosed as requested in this authorization My Health Information may no longer be protected by federal and state privacy laws and potentially may be re-disclosed by the person who is receiving my information.

I am not required to sign this authorization. Johns Hopkins does not condition treatment, payment, benefit eligibility or enrollment activities on the signing of this form. 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.

Patient Name: _____
(first) (m. initial) (last)

Signature: _____ **Date:** _____

Address: _____
(street address) (apt. number)

_____
(city) (state) (zip code)

Phone: _____
(area code) (home phone number)

Birth Date: _____ **Medical Record #:** _____

As the healthcare agent/court appointed guardian/parent/informal kinship care relative, I,
(circle one of the above)

_____ **confirm that I am the representative for the patient as circled above.**
(insert your name)

Representative's Signature: _____

Address: _____ **Phone:** _____

If you are the healthcare agent, court appointed guardian, or relative providing informal kinship care, please attach proof of your authority to act on behalf of the patient.

By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization.

Notice to the Individual signing this form: The confidentiality of information concerning alcohol or drug abuse treatment is protected by federal law (Federal Regulation 42 CFR Part 2) and prohibits the recipient from further disclosing this information except with specific written authorization of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient for that purpose.

I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to the Health Care Provider identified above that provided the health information.

If I am unable to provide a copy of the original authorization with my request to revoke, I will provide the following information.

- Date of the authorization,
- Name,
- Address,
- Phone number,
- Medical record number,
- Date of birth,
- Purpose of authorization,
- A description of the health information covered by the authorization,
- The person or entity authorized to use the data.

If the form was signed by my representative, the request will also include:

- The representative's name,
- Relationship,
- Address and
- Phone number.

I understand that if I am unable to provide all of the above information, Johns Hopkins may not be able to honor my revocation request.