(1) ONE YEAR AUTHORIZATION (AGREEMENT) FOR RELEASE OF HEALTH INFORMATION TO JOHNS HOPKINS HEALTHCARE LLC

All items on this agreement should be completed or the request may not be honored. If the information requested does not apply to you, use "N/A", in the space, showing it does not apply.

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

Address: _____
(street address)

_____
(city) (state) (zip code)

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

Birth Date: _____

For this agreement, "**My Health Information**" means:

☐ Complete Record	☐ Lab Tests	☐ Discharge Summaries	☐ Sonogram
☐ Inpatient Record	☐ Operative Reports	☐ Progress Notes	☐ _____
☐ Outpatient Record	☐ Cath Reports	☐ Risk Assessments	☐ _____
☐ Emergency Dept. Record	☐ Cardiology Studies	☐ Prenatal Labs	☐ _____
☐ Mental Health Record	☐ EKG	☐ Prenatal Flow Sheet	☐ _____

☐ for the date(s) starting and ending: _____ OR ☐ for all time periods for which records exist
[insert date(s) for time period requested]

I am in agreement to have all of my health care providers ("Health Care Provider") to provide **My Health Information** to

_____ for _____
[insert name of JHHC department or person] [insert purpose for use or disclosure]

_____.

My Health Information should be faxed to _____ **OR** sent to:

_____
[insert contact name at JHHC]

6704 Curtis Court

Glen Burnie, Maryland 21060

_____

V:\HIPAA-New\Operations\Policies_Forms\Health Plans\Forms\B 2 1 f Auth To.JHHC.CareMgt.doc
H:\Website\Compliance\HIPAA 2.1 f. One Year Authroization for Release of Information TO JHHC 1208 v.docx

Privacy Office Effective Date: 12/1/08
JHHC 2.1.f.

Read the statements below. The agreement is legal only when it is signed by you or signed by your legal representative in the box provided below.

- I understand that once **My Health Information** is given, as requested in this agreement, **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 know I am not required to sign this agreement. I understand that the Health Care Provider may not treat me any differently for signing or not signing this form.

- I know if I do not sign this agreement, my Health Care Provider will not disclose **My Health Information** to Johns Hopkins HealthCare.

- I know I may receive a copy of this agreement when I sign it.

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

- By signing this agreement, I understand that health information released may be sensitive as it applies to me. Some examples are medical illnesses such as: HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

- I understand that release of psychotherapy notes requires an additional agreement.

Patient Signature: _____ **Date:** _____

If anyone other than the patient signs this form, please complete the following:

I, _____, confirm that I am the: (circle one below)
(print your name)

****healthcare agent** ****court appointed guardian** **custodial parent** **of the patient.**

Representative's Signature: _____ **Date:** _____

Address: _____ **Phone:** _____

*****If you are the healthcare agent or court appointed guardian,***

you must attach proof of your authority to act on behalf of the patient.