JOHNS HOPKINS UNIVERSITY

Student Health and Wellness Center
1 East 31st Street, N200
Baltimore, MD 21218
Tel: 410-516-8270 Fax: 410-516-4784

Patient label

Consent for Release of Medical Information From JHU SHWC

Student Full Name_____
Student Date of Birth _____/____/_____ Phone Number _____
Last Year Attended: _____

Consent:

By signing this form, I consent to the following:

#1) Johns Hopkins University (JHU) may disclose the medical records and information I specify below from the JHU Student Health and Wellness Center to the individual or entity specified in #2, upon request:

Please check the appropriate box(es):

☐ All of my medical records and information*^, **EXCEPT** medical records and information regarding:
- ☐ Mental health
- ☐ Reproductive health, including information about contraception
- ☐ Sexually transmitted infections, including HIV and AIDS
- ☐ Drug and alcohol use
- ☐ Other (*please specify*) _____

OR

☐ All of my medical records and information*^

OR

☐ ONLY Immunization information

AND/OR

□ ONLY Information about my appointments and whether I have been to or am in the Student Health and Wellness Center

AND/OR

☐ Other (*please specify*) _____

#2) The medical records and information specified in #1 may be disclosed to:

Name (individual, entity or JHU office) _____
Address _____
Email Address _____ Phone Number _____
Fax Number _____

#3) The above disclosures may be made for the purposes of (*check appropriate box(es)):*

☐ Keeping my parents informed of my medical and health care and treatment and health status
☐ Giving another health care provider information about my health history so they can provide care or treatment to me
☐ Other _____

#4) I understand that:

- This consent expires one year from the date on which I sign it, unless I revoke it earlier in writing.
- I can revoke this consent at any time upon the JHU Student Health and Wellness Center's receipt of my signed, dated revocation. The revocation does not affect disclosures that were made prior to JHU's receipt of the revocation.
- Signing this consent is voluntary.
- I cannot be denied any educational or health services from JHU if I do not sign this consent.

Student Signature: _____ **Date:** _____

* "All my medical records and information" applies only to medical records and information developed and maintained by the JHU Student Health and Wellness Center. If you would like to authorize JHU to disclose medical records pertaining to you that the JHU Student Health and Wellness Center has received from another health care provider, please check the box marked "Other" and specify the records.

^ Note that this does not include psychotherapy notes created by the JHU Counseling Center. A separate consent is required to release psychotherapy notes from the JHU Counseling Center. However, my medical records may include some mental health information related to any visits to or treatment I may receive from the Counseling Center (i.e. diagnosis, medications, etc.).