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 to JHU SHWC*

For this authorization, "My Health Information" includes _____

_____.
[insert description of health information]

I authorize _____ ("Health Care Provider") to provide My Health
[insert name of other health care provider]

Information to The JHU Student Health & Wellness Center for _____
[insert purpose for use or disclosure]

_____.

My Health Information should be faxed to 410-516-4784 OR sent to:

Attn:_____
The Johns Hopkins University
Student Health & Wellness Center
1 East 31st Street, N 200
Baltimore, MD 21218

This authorization is valid for one year from date signed, unless I revoke this authorization. Johns Hopkins may contact me to extend this authorization, but I do not have to do so.

I understand that there is the potential for My Health Information to be redisclosed and to lose the protection of applicable privacy laws and regulations.

I am not required to sign this authorization. I understand that the Health Care Provider may not condition treatment, payment, benefit eligibility or enrollment activities on the signing of this form. However, if I do not sign this authorization, my health care provider will not disclose my health information to Johns Hopkins. I will receive a copy of this authorization upon signature.

I may revoke this authorization at any time in writing by following the guidelines on the second page of this form.

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

Signature: _____ **Date:** _____

Address: _____
(street address)

_____
(city) (state) (zip code)

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

School Enrolled: _____ **Status: ___U/G ___Grad ___PD**

Birth Date: _____

** Not to be used in connection with health information from substance abuse treatment programs.*

For healthcare agent/guardian/surrogate/parent,
(circle one of the above)

I, _____, represent 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 or guardian, 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.

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 to Johns Hopkins.

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, the health care provider may not be able to honor my revocation request.