HIM ROI Authorization

JOHNS HOPKINS REQUEST BY PATIENT OR PATIENT REPRESENTATIVE FOR COPY OF HEALTH INFORMATION

Patient Name: _____ **Birth Date:** _____

Full Address: _____ **Phone #:** _____

_____

☐ **Provide a copy of** My Health Information **to me**

☐ Send **My Health Information** to: _____

_____
(name of other person or entity/address)

For this Request, **"My Health Information"** means (check one or more):

☐ Hospital Inpatient Abstract (Patient Demographics, Admission information, Discharge Summary, Emergency Department note(s), History & Physical, consult operative note(s), Operative Report(s), Procedure Notes, and Results)

☐ Billing Record
☐ Diagnostic Test/Results (lab, x-rays and other test results)
☐ Discharge Summary
☐ Operative Report
☐ Emergency Room Record
☐ History & Physical
☐ Immunization Record
☐ Mental Health Records
☐ Other: _____
☐ Outpatient Record
☐ Pathology Report
☐ Progress Note
☐ Radiology Images (CD or DVD)

From: _____
(name of Johns Hopkins health care provider)

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

For the date(s) of service from: _____ to _____ (records will be provided for all service dates if left blank)

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

☐ on paper ☐ electronically on CD ☐ electronically on flash drive ☐ by fax to _____
(unable to verify number before faxing)

☐ to my MyChart account (Note: Records are retained and stored in various forms, and large volume requests cannot be provided through MyChart.)

☐ through a web portal (where possible/available), with notice provided to my email account at: _____

☐ by e-mail to this email address: _____

☐ by other electronic means (if agreed upon by JH records department): _____

☐ unencrypted ☐ encrypted

Important: I understand that if the CD/disc or flash drive is not encrypted or password protected, it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device. I understand that unencrypted e-mail is not secure. There is a possibility that information included in an email can be intercepted and/or misaddressed/misdirected and read by other parties besides the person to whom it is addressed. By choosing to receive **My Health Information** on an unencrypted CD/disc, flash drive or by unencrypted e-mail, I am acknowledging and accepting these risks. 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. I agree to pay this fee.

Signature of Patient Only: _____ **Date**: _____/_____/_____ (Required)
If you are NOT the patient but are signing on behalf of the patient, please complete below and attach proof of your authority to act on behalf of the patient/plan member (other than parent).

I, _____, **am the (check which applies)**
(print your name)

☐ **Parent with Parental Rights** *(applies only to minors) (not sufficient for substance abuse records)*
☐ **Informal Kinship Care Relative** *(applies only to minors) (Maryland only) (not sufficient for substance abuse records)*
☐ **Legal Guardian**
☐ **Patient/Plan Member Appointed Decision Maker** *(e.g., power of attorney) (not sufficient for substance abuse records)*
☐ **Default Substitute Decision Maker** *(e.g., surrogate, proxy (not sufficient for behavioral health/substance abuse records)*
☐ **Court Appointed Personal Representative of Deceased, Executor or Administrator**

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