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/fax number)

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

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

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

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

If I have initialed here (_____), this Request does NOT include records from other healthcare providers that are a part of my Johns Hopkins records included in this request. (If this blank is not initialed, those records ***will be*** included.)

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

☐ 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. Additionally, I understand that unencrypted e-mail is not secure – that means it could be intercepted and seen by others; in addition, I understand that there are other risks with unencrypted e-mail including misaddressed/misdirected messages; e-mail accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. 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. I 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 (other than parent).

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

☐ **Parent with Parental Rights** *(not sufficient for substance abuse records)*
☐ **Registered Kinship Care Relative** *(not sufficient for substance abuse records)*
☐ **Court Appointed Guardian**
☐ **Legally Appointed Healthcare Agent** *(not sufficient for substance abuse records)*
☐ **Power of Attorney with Right to See Medical Records** *(not sufficient for substance abuse records)*
☐ **Surrogate Decision Maker** *(not sufficient for substance abuse records or mental health records)*
☐ **Court Appointed Personal Representative of Deceased**

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