

AUTH TO DISCUSS HEALTH INFO

JOHNS HOPKINS INSTITUTIONS

STANDING AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS

Complete all sections of this Authorization as appropriate to your request.

		0 0	Birth Date:
Address: (first)	(m. initial)	(last)	Phone #:
Address.	(street address)		
(altr)	(state)	(zip code)	Medical Record #:(if known)
(city)	(state)	(zip code)	(ii khomi)
For this Authorization, "My Health	n Care Provider means	(Name of Facility, Speci	fic Physician or Provider, or etc.)
For this Authorization, "My Healt	h Information" means any and	all information relating	to my course of examination and treatment.
If I have initialed here (), "My Health Information	tion" includes Subs	stance Abuse Records/Information.
If I have initialed here (), "My Health Informa"	tion" includes Beha	vioral Health Records/Information.
I authorize My Health Care Pr for general information and in payment and any other relate	quiries, arranging appointme	n Information with the ents, identifying medi	e person(s) or entity identified below cations, discussing billing and
Name:		Name:	
Phone #:		_ Phone #:	
I understand that:			
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