



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: CD SERVICES INC 24027 RESEARCH DRIVE (248-476-6600) FARMINGTON HILLS, MI 48335

(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: ALL RECORDS FROM TO

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: Records@cdservicesinc.com
by e-mail to this email address: Records@cdservicesinc.com
by other electronic means (if agreed upon by JH records department): Records@cdservicesinc.com
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)