US FAMILY HEALTH PLAN

7231 Parkway Dr., Suite 100

Hanover, MD 21076

JOHNS HOPKINS HEALTH PLANS

AUTHORIZATION OF THIRD-PARTY REPRESENTATIVE

To protect the privacy of medical information and ensure we take direction from the correct individual, **Johns Hopkins Health Plans**—on behalf of the **Johns Hopkins Uniformed Services Family Health Plan (USFHP)**—asks that you complete and return this form so we can verify your identity and confirm that the information matches our records.

Plan Member Information (*All information MUST be completed*)

Name: _____ **Relationship:** _____
(first) (m. initial) (last)

Address: _____ **Phone #:** _____
(street address)

_____ **Plan Member #:** _____
(city) (state) (zip code) (if known)

Representative Information (*All information MUST be completed*)

Name: _____ **Relationship:** _____
(first) (m. initial) (last)

Address: _____ **Phone #:** _____
(street address)

_____
(city) (state) (zip code)

What Authorization You are Providing

For this Authorization, I hereby authorize the above **Representative** to do the following on my behalf (check one or more):

☐ Discuss Complete Records (includes Case/Medical and Payment Records)
☐ Discuss Case/Medical Management Records
☐ Discuss Payment Records

☐ Other _____

For Tricare Young Adult Only:

☐ Make Changes to Payment Information
☐ Make Payments
☐ Initiate Voluntary Disenrollment

I approve the release of the following types of sensitive records and information (Optional). Unless checked, this information will NOT be included:

☐ Substance Abuse Records
☐ Behavioral Health Records
☐ Reproductive Health Records

Authorized Dates of Service

For date(s) of service from: _____ to: _____ **OR** ☐ **ALL Dates of Service**

(*Note: Information from recent visits may not yet appear in the record.*)

Authorization Expiration Date

Expiration Date for this Authorization: _____ **OR** ☐ **No Expiration**

I understand that:

- This Authorization is voluntary and will not affect enrollment, eligibility for benefits. and payment for treatment.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws and could be re-disclosed by the person(s) receiving it.
- **Unless specified above, the medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, behavioral health, drug and alcohol abuse, etc.**
- I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to:

Johns Hopkins Health Plans
Attn: Corporate Compliance Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076
Phone: 410-424-4996
Email: HIPAAPrivacy@jhhp.org

Once you have completed this form, please return it by email or mail to the Johns Hopkins Health Plans Corporate Compliance Department at the contact information above.

Signature of Plan Member Only: _____ **Date:** _____
(*Both Fields Required if Completed by Plan Member*)

Email Address Plan Member Only: _____

If you are NOT the Plan Member and are signing on behalf of the Plan Member, please complete below.

I, _____,
(*print your name – **REQUIRED***)
certify that I am legally authorized to act on behalf of the member in the capacity checked below and that the information provided is true and correct:

- ☐ **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)
- ☐ **Appointed Personal Representative of Deceased, Executor or Administrator**

Representative's Signature: _____ **Date:** _____
(*Both Fields Required*)

Representative Email Address: _____

You MUST attach proof of your authority to act on behalf of the patient/plan member as checked above (other than Parent with Parental Rights).