The Johns Hopkins Hospital

Baltimore, Maryland 21205

RELEASE OF MEDICAL INFORMATION

(For Releases to Physicians, Insurance Companies, and Legal Counsel)

I, ______________________________ JHH History # ______________

HPPC History # ______________

____
Date of Birth

__________ Race __________ Sex

____
Father's Name

____
Mother's Maiden Name

Do authorize the Johns Hopkins Medical Institutions to release any and all findings and information in connection with my examinations, care and treatment at The Johns Hopkins Hospital during the period of/or about

______________________________ To ______________________________
Day Month Year Day Month Year

To ______________________________
Name

____
Address

____

This consent will expire sixty (60) days from the date hereof unless otherwise stipulated ______________________________

I understand that I may revoke my consent to release information from my records, but not retroactive to release of information already made in good faith.

Signature ______________________________ Date ______________________________

____
Signature of Parent, Relative, or Legal Guardian, where applicable

______________________________ Date ______________________________
Witness

15-141120 3/81