AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO JOHNS HOPKINS
PHYSICIAN TO PHYSICIAN REQUEST

All items on this authorization must be completed or the request will not be honored. Use "N/A" if not applicable.

Patient Name:	_____ (first) (m. initial) (last)
Address:	_____ (street address)
	_____ (city) (state) (zip code)
Birth Date:	_____

For this authorization, "My Health Information" means **all clinical notes, radiology reports, lab results, operative notes and actual radiology images on films or CDs**.

I authorize _____ ("Health Care Provider") to provide My Health
[insert name of other health care provider]
Information to **Johns Hopkins Center for CSF Disorders** for treatment purposes.

My Health Information should be faxed to **410-955-9126 OR** sent to: Dr. Daniele Rigamonti / Dr. Abhay Moghekar, Johns Hopkins Hospital, 600 N. Wolfe Street, Phipps 126, Baltimore, MD 21287

I understand that:

- This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not.
- If I do not sign this authorization, My Health Care Provider will not disclose My Health Information to JHH.
- I will receive a copy of this authorization upon signature.
- This authorization is valid for one year from the date signed, unless I revoke this authorization or unless an earlier date is specified here: _____. I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to the Health Care Provider identified above that provided the health information to Johns Hopkins.
- 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.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature of Patient only: _____ Date: _____
(Required)

If you are NOT the patient but are signing on behalf of the patient complete the following:

I, _____, confirm that I am the legally appointed representative for the patient and I have CIRCLED my relationship to the patient below:

Parent with Parental Rights
Registered Kinship Care Relative
Legally Appointed Healthcare Agent
Court Appointed Guardian
Court Appointed Personal Representative of Deceased
Power of Attorney with Right to See Medical Records
Medical Power of Attorney
Surrogate Decision Maker

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

Address: _____ **Phone:** _____
You must attach proof of your authority to act on behalf of the patient as circled above (other than parent).