EP00002

Johns Hopkins Institutions
Department of Radiology

For Radiology Staff Use Only			
Date Received		Date Order Completed	
Time Received		Time Order Completed	
Staff Initials		Staff Initials	

Fill Out at Records Pickup

Customer Signature: _____ **Date:** _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO THIRD PARTIES

PLEASE FILL OUT COMPLETELY

Patient Information

Medical Record Information:

Medical Record Number | Date of Birth (MM/DD/YYYY)

Patient Name:

First | Middle | Last

Address:

Street Address & Apartment Number (No PO Boxes)

City | State | Zip Code

Phone:

Home phone (with area code) | Alternate phone (with area code)

Radiology Images and/or Reports Requested

For this request, "**My Health Information**" is: **Radiology Images and/or Radiology Reports**

Exam Date	Modality (CT, MRI, Neuro, NucMed, PET, Ultrasound, X-Ray)	Type of Exam (Head, Chest, etc.)	*(Radiology Staff Use Only)* Accession Number

Format

I request that the copy be provided:

☐ electronically on CD

☐ by unencrypted e-mail to (report only; images cannot be e-mailed) this email address: _____

☐ electronically through Image Sharing (if available) to this email address: _____ _____

☐ by other electronic means (if agreed upon by JH records department): _____

Important: I understand that the CD/disc is not encrypted or password protected and that it is my responsibility to take extra precautions to protect the data on the disc and not to lose or misplace the disc. 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 a CD/disc or by unencrypted e-mail, I am acknowledging and accepting these risks.

PLEASE READ THE SECOND PAGE AND SIGN TO COMPLETE THE AUTHORIZATION

Patient Authorization

I authorize _____ to disclose **My Health Information**
[insert Johns Hopkins organization]

☐ to me ☐ to another person or entity

_____ for _____.
[Insert name of person or entity] [Insert purpose]

My Health Information should be faxed to _____ **OR** sent to:
[Insert fax number]

_____
[Insert contact name at entity, if applicable]

_____
[Insert street address]

_____
[Insert city, state and zip code]

I understand there is a charge for copying and handling my request. I understand that all fees will be in compliance with applicable law. By signing this Authorization, I agree to pay these fees at the time this request is made.

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization, or unless an earlier date is specified here: _____. 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 eRadiology Center 600 N. Wolfe Street Nelson B104 Baltimore, MD 21287 Fax: 443-769-1210	Johns Hopkins Imaging at Green Spring Station 10755 Falls Road Lutherville, Maryland 21093 Fax: 410-583-2894	Johns Hopkins Imaging at White Marsh 4924 Campbell Boulevard, Suite 105 Baltimore, Maryland 21236 Fax: 443-442-2410	Bayview Medical Center Department of Radiology 4940 Eastern Avenue Baltimore, MD 21224 Fax: 410-550-0210

Howard County General Hospital Diagnostic Imaging Film Library 5755 Cedar Lane Columbia, MD 21044 Fax: 410-740-7591	Suburban Hospital Radiology Department 8600 Old Georgetown Road Bethesda, MD 20814 Fax: 301-896-7399	Sibley Memorial Hospital Imaging Services Department 5255 Loughboro Road, NW Washington, DC 20016 Fax: 202-363-6984

- 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, please complete below:

I, _____, **am the (check which applies)**
(print your name)

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

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

Address: _____ **Phone**: _____

You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).