



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: |
| <input type="checkbox"/> electronically on CD |
| <input type="checkbox"/> by unencrypted e-mail to (report only; images cannot be e-mailed) this email address: _____ |
| <input type="checkbox"/> electronically through Image Sharing (if available) to this email address: _____ |
| <input type="checkbox"/> 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 | Johns Hopkins Imaging at Columbia 11055 Little Patuxent Parkway, Suite L9 Columbia, MD 21044 Fax: 410-730-4214 |
| 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 | Johns Hopkins Imaging at Bethesda 6420 Rockledge Drive Suite 3100 Bethesda, MD 20817 Fax: 301-897-7333 | 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)

- | | |
|---|---|
| <input type="checkbox"/> Parent with Parental Rights | <input type="checkbox"/> Registered Kinship Care Relative |
| <input type="checkbox"/> Court Appointed Guardian | <input type="checkbox"/> Legally Appointed Healthcare Agent |
| <input type="checkbox"/> Medical Power of Attorney | <input type="checkbox"/> Power of Attorney with Right to See Medical Records |
| <input type="checkbox"/> Surrogate Decision Maker | <input type="checkbox"/> 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).