JOHNS HOPKINS HOSPITAL
Department of Radiology
eRadiology Center
600 N Wolfe St. Nelson B104
Baltimore, MD 21287
Phone: 443-287-7378
Fax: 443-769-1210

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

Patient Authorization

I authorize Johns Hopkins Hospital to disclose My Health Information to ☐ 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]

PLEASE READ THE SECOND PAGE AND SIGN TO COMPLETE THE AUTHORIZATION

Patient Authorization (Cont'd)

I understand there is a charge for copying and handling my request. I understand that all fees will be in compliance with applicable state and federal guidelines. 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.
- If I do not sign this authorization, Johns Hopkins will not disclose My Health Information as requested.
- I will receive a copy of this authorization upon signature.
- This authorization is valid for one year from date signed, unless I revoke this authorization, or unless an earlier date is specified here: _______________ (Date). I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to:

  Johns Hopkins Hospital
  Department of Radiology
  600 N. Wolfe Street
  Baltimore, MD 21287

- 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, __________________________________, (Print your name)

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**
- **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 circled above (other than parent).