

**JOHNS HOPKINS HOSPITAL**  
**Department of Radiology**

**AUTHORIZATION FOR RELEASE OF  
HEALTH INFORMATION TO THIRD PARTIES**  
NOT TO BE USED TO RELEASE PATIENT'S OWN RECORDS  
TO PATIENT (USE HIPAA FORM A.6.2.a)

**PLEASE FILL OUT COMPLETELY**

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: _____

Patient Information	
<b>Medical Record Information:</b>	Medical Record Number _____ Date of Birth (MM/DD/YYYY) _____
<b>Patient Name:</b>	First _____ Middle _____ Last _____
<b>Address:</b>	Street Address & Apartment Number (No PO Boxes) _____ City _____ State _____ Zip Code _____
<b>Phone:</b>	Home phone (with area code) _____ Alternate phone (with area code) _____

Radiology Images and/or Reports Requested			
For this request, "My Health Information" is: <b>Radiology Images and/or Radiology Reports</b>			
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 _____ [Insert name of person or entity]	
for _____ [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 state and federal guidelines. By signing this authorization, I agree to pay these fees at the time this request is made.	
I understand that once My Health Information is disclosed as requested in this authorization, My Health Information may no longer be protected by federal and state privacy laws and potentially may be re-disclosed by the person who is receiving my information.	
I am not required to sign this authorization. Johns Hopkins does not condition treatment, payment, benefit eligibility or enrollment activities on the signing of this form. 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 at any time in writing by following the guidelines on the back of this form.	
By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.	
Patient Signature: _____ Date: _____	
For healthcare agent (including holder of a medical power of attorney), court appointed guardian, authorized surrogate, parent of a minor, informal kinship care relative, holder of a general power of attorney with the specific right to see medical records, or Personal Representative of the deceased: (Circle one of the above)	
I, _____, confirm that I am the representative for the patient <u>as circled above</u> . (Print your name)	
Representative's Signature: _____ Date: _____	
Address: _____ Phone: _____	
If you are the healthcare agent, court appointed guardian, holder of a power of attorney, relative providing kinship care or court appointed Personal Representative of the deceased, you must attach proof of your authority to act on behalf of the patient.	

**How To Revoke Authorization:**

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

If I am unable to provide a copy of the original authorization with my request to revoke, I will provide the following information:

- Date of the authorization
- Name
- Address
- Phone number
- Medical record number
- Date of birth
- Purpose of authorization
- A description of the health information covered by the authorization
- The person or entity authorized to use the data

If the form was signed by my representative, the request will also include:

- The representative's name
- Relationship
- Address
- Phone number

I understand that if I am unable to provide all of the above information, Johns Hopkins may not be able to honor my revocation request.