

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

For this authorization, "My Health Information" is:

- |  |   |
|--|---|
| <input type="checkbox"/> PPD skin test report  | <input type="checkbox"/> Mammogram report |
| <input type="checkbox"/> History & Physical / Consults                                 | <input type="checkbox"/> Pap Smear report |
| <input type="checkbox"/> Colonoscopy Report  | <input type="checkbox"/> Other: _____     |
| <input type="checkbox"/> Exercise Stress Test w/Echo                                   | <input type="checkbox"/> Other: _____     |
| <input type="checkbox"/> Diagnostic Test/Results (labs, x-rays and other test results) |   |

For the date(s) of service starting: \_\_\_\_\_  
 [insert date(s) of service requested]

I authorize \_\_\_\_\_  
 [insert name of physician or Medical Facility]

to disclose My Health Information to **Johns Hopkins Hospital** for the purpose of a Kidney Donor Evaluation.

My Health Information should be sent to:  
**Johns Hopkins Hospital**  
**Kidney/Pancreas Transplant Office**  
**Core Kidney Donor Office**  
**720 N. Rutland Avenue, Turner 36**  
**Baltimore, Maryland 21205**  
**or Fax To: 410-614-6906**

This authorization is valid for one year from date signed, unless I revoke this authorization. Johns Hopkins may contact me to extend this authorization, but I do not have to do so.

Johns Hopkins' medical and administrative staff is pledged to maintain strict patient confidentiality in keeping with high ethical standards and in accordance with state and federal law. Johns Hopkins has procedures in place to support this policy. These procedures make it very unlikely that my health information will be improperly redisclosed. However, if this happens, my health information may no longer be covered by these privacy protections.

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. I will receive a copy of this authorization upon signature. I may revoke this authorization at any time in writing by following the guidelines on the second page of this form.

<b>Patient Name:</b>	_____ (first)	_____ (m. initial)	_____ (last)
<b>Signature:</b>	_____		<b>Date:</b> _____
<b>Address:</b>	_____ (street address)		
<b>Phone:</b>	_____ (city)	_____ (state)	_____ (zip code)
<b>Medical Record #:</b>	_____ (area code) _____ (home phone number)		
<b>SSN:</b>	_____	<b>Birth Date:</b>	_____



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. I understand that release of psychotherapy notes requires an additional authorization.

Notice to the recipient of these records: If the information concerns a person treated for alcohol or drug abuse, the confidentiality of this information is protected by federal law (Federal Regulation 42 CFR part 2) and prohibits further disclosure of this information except with specific written authorization of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient for this purpose.

I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to the medical records department where my request was made.

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,
- Social security 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 and
- 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.

