JOHNS HOPKINS INSTITUTIONS

AUTHORIZATION FOR USE OF INFORMATION AND PHOTOGRAPHS

Patient Name: ____
(first) (m. initial) (last)

Address: ____
(street address)

____
(city) (state) (zip code)

Medical Record #: __________________ **Birth Date:** __________________ **Telephone # :** __________________
(if known)

Johns Hopkins Medicine is grateful to patients who are willing to share their stories. Information about treatment you received here, the people you met and your experiences can prove enormously helpful to others interested in knowing more about health care today.

At the same time, the privacy of patients and visitors, as well as the confidentiality of medical and related information, are among our highest priorities. Therefore, permission always is sought from patients or their families or guardians to provide names, photos and information about hospitalization and treatment to the news media. A permission is also sought to use this information and visual material in official Hopkins communications, such as publications, articles, brochures, Web sites, video and audio tapes.

To make certain that we are using your personal information with your authorization, Hopkins keeps on file a copy of your written permission. Would you, therefore, please take a minute to fill out and sign this form? (Place your initials in the appropriate space for each bulleted item.)

- I do ____, do not ____ give my permission for Johns Hopkins to share information about my treatment and experiences as a Hopkins patient in publications produced by Johns Hopkins. This permission extends both to electronic versions on the Johns Hopkins Web sites and printed versions.
- I do ____, do not ____ give my permission for Johns Hopkins to use my photographs or images in publications produced by Johns Hopkins. This permission extends to both electronic versions on the Johns Hopkins Web sites and printed versions.
- I do ____, do not ____ give my permission for Johns Hopkins to use my information, photographs and images in electronic media (DVDs, CDs, digital files, podcasts, vodcasts, WMF and similar) produced by Johns Hopkins on Johns Hopkins web sites and on Johns Hopkins portals or channels on external sites such as Facebook, You Tube and similar sites.
- I do ____, do not ____ give permission for Johns Hopkins to provide my name and contact information to the public news media including, but not limited to, TV, radio and newspapers in connection with my treatment and experience as a Hopkins patient.
- I do ____, do not ____ give permission for Johns Hopkins to disclose my photographs or other images, or information about my treatment and experiences as a Hopkins patient, to the public news media including, but not limited to, TV, radio and newspapers, and to other commercial media photographers and videographers.
- I do ____, do not ____ give permission for Hopkins to allow TV, radio, newspapers and other commercial media photographers and videographers to make images of me/my child(ren)/my family member for purposes of illustrating my treatment and experience as a Hopkins patient.
- I do ____, do not ____ give permission for Johns Hopkins to provide my name and contact information, and to disclose my photographs or other images, or information about my treatment and experiences as a Hopkins patient, to an individual author or publisher: ____

If any of the permissions above are given, I hereby release and waive all claims to compensation and rights regarding such use and/or publication.

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.
- This Authorization is valid for one year from date signed, meaning that Johns Hopkins has one year to print or publish my story, photographs or other images, or to share my name and information with the public news media.
- I may revoke/withdraw this Authorization by mailing or faxing my written request along with a copy of the original Authorization to the clinic or department where my Authorization was made or given or to Johns Hopkins Medicine's department of Marketing and Communications. Any revocation/ withdrawal of this Authorization would affect only any new use and disclosure of my information, photographs and images, which have not been previously published or disclosed by Johns Hopkins. I understand that this withdrawal would <u>not</u> affect any non-Johns Hopkins TV, radio, newspaper and other commercial media once they have received my information or recorded my image.
- 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)

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

- ☐ **Parent with Parental Rights** *(not sufficient for substance abuse records)*
- ☐ **Registered Kinship Care Relative** *(not sufficient for substance abuse records)*
- ☐ **Court Appointed Guardian**
- ☐ **Legally Appointed Healthcare Agent** *(not sufficient for substance abuse records)*
- ☐ **Medical Power of Attorney** *(not sufficient for substance abuse records)*
- ☐ **Power of Attorney with Right to See Medical Records** *(not sufficient for substance abuse records)*
- ☐ **Surrogate Decision Maker** *(not sufficient for substance abuse records or mental health records)*
- ☐ **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).

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