JOHNS HOPKINS INSTITUTIONS

Heart Hype / Hypertrophic Cardiomyopathy
Johns Hopkins Medicine
Division of Cardiology
1800 Orleans Street, Sheikh Zayed Tower #4052
Baltimore, Maryland 21287
410-502-6646

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 # :** _____

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?

- 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.

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.
- I will receive a copy of this authorization upon signature.
- This authorization will end only when the use and disclosure of my information is no longer needed for the purposes agreed to above. I may revoke 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.
- This withdrawal would affect only future 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 not 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)

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).

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