JOHNS HOPKINS INSTITUTIONS

AUTHORIZATION FOR TAKING AND DISCLOSURE OF AUDIO/VIDEO TAPES

This Form Requests Your Permission to Use Your Information for Educational Purposes

Complete all sections of this Authorization as appropriate to your request.

Patient Name: ____ **Birth Date:** ____________________
(first) (m. initial) (last)

Address: ____ **Phone #:** ______________________
(street address)

____ **Medical Record #:** ______________
(city) (state) (zip code) (if known)

I hereby give ______________________________ (Johns Hopkins) permission to allow audio and video taping of the patient identified above to be used by the _____________________________ (School) for educational purposes only.

I authorize Johns Hopkins to provide copies of any such audio or video tape to (i) the School for the student to share with his/her program at the School and (ii) those certain vendors that the School has engaged to provide services to the program.

I hereby release and waive all claims to compensation and rights regarding such tapes.

I understand that:

- This Authorization is voluntary. The patient's 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 take the audio/video tapes or disclose my health information, as applicable.
- This Authorization is valid for one year from date signed, unless I revoke this Authorization or unless an earlier date is specified here: _______________.
- Once the health audio/video tape is disclosed to the School, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- I may revoke/withdraw this Authorization at any time in writing by mailing or faxing my written request along with a copy of the original Authorization to Johns Hopkins. I understand that this withdrawal would not affect any disclosures made in reliance of this authorization prior to receiving the revocation.

Signature of Patient Only: ____ **Date**: _____/_____/_____
(Required)

If you are NOT the patient but are signing on behalf of the patient, please complete below.

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

- ☐ **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**

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).