JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTH SYSTEM

# THE JOHNS HOPKINS CONSENT TO CREATE AND USE *IMAGES AND RECORDINGS* AND AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

**Patient Name:**_____
(first) (m. initial) (last)

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

I acknowledge that I have read the Johns Hopkins Imaging and Recording Patient Education Guide found on the back of this Consent and Authorization. I understand that "*Images and Recordings*" for the purpose of this Consent and Authorization include, but are not limited to, photographs, drawings, videotapes, digital/electronic images, audio recordings, motion pictures or other images and related health information. I understand my rights, or the rights of the patient I represent, when *Images and Recordings* are made, used and released for distribution and have had any questions answered.

**Please initial where indicated below and sign the bottom of the form. If you do not agree to a specific item listed within the section, please cross that item out with a single line.**

## I. Permission to make and/or use *Images and Recordings* for Johns Hopkins **internal use**.

_____ I agree _____ I do not agree
***initial*** ***initial***

To allow Johns Hopkins staff members or _____to make *Images and Recordings*
*Authorized non-Johns Hopkins Person or entity*
of me, or the patient I represent for **internal use by Johns Hopkins**, such as, internal education, quality improvement or other purpose as described: _____. I understand that whenever possible the *Images and Recordings* will be modified so that I am not recognizable.

## II. Permission to make and/or use *Images and Recordings* in which **I am not identifiable,** for use external to Johns Hopkins.

_____ I agree _____ I do not agree
***initial*** ***initial***

To allow Johns Hopkins staff members and authorized non-Johns Hopkins persons to make and use *Images and Recordings* of me, or the patient I represent, in which **I am not identifiable** for use outside of Johns Hopkins. These external uses include but are not limited to: external education, lectures, printed and electronic publications, research, publicity and media distribution, fundraising, websites or other external purpose (describe):

_____
_____.

## III. Permission to make and use *Images and Recordings* in which **I am identifiable** for use **external to Johns Hopkins.**

_____ I agree _____ I do not agree
***initial*** ***initial***

To allow Johns Hopkins staff members and authorized non-Johns Hopkins persons to make *Images and Recordings* of me or the patient I represent, and give permission for Johns Hopkins to release my **identifiable** images and recordings, and/or health information to be used for, but not limited to, external education, research, lectures, printed and electronic publications, publicity and media distribution, marketing materials, fundraising, websites or other external purpose (describe):

_____

_____.

_____.

_____ I acknowledge that Johns Hopkins *(please check one)* ☐ **will** ☐ **will not** receive financial or
***initial*** non-financial compensation in exchange for my *Images and Recordings*.

***THE JOHNS HOPKINS CONSENT TO CREATE AND USE IMAGES AND RECORDINGS AND AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION***

***I understand that***:

- This Consent/Authorization is voluntary. My treatment will not be impacted whether I sign this Consent/Authorization or not.
- If I do not sign this Consent/Authorization, Johns Hopkins will not disclose my protected health information.
- This Consent/Authorization will end only when the use and disclosure of my information is no longer needed for the purposes agreed to above.
- I understand that I may verbally request cessation of imaging or recording at any time while image or recording is being made.
- I hereby release and waive all claims to compensation and rights regarding the permissions and authorizations I initialed on this Consent/Authorization form.
- I may revoke/withdraw this Consent/Authorization by mailing or faxing my written request to the care provider, clinic or department where my consent and/or authorization was made or given; or to Johns Hopkins Medicine's Marketing and Communications, Media Relations and Public Affairs Department at 901 S. Bond Street, Suite 540, Baltimore, MD 21231. This withdrawal would affect any new use and disclosure of my information, images, and recordings 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, other educational institutions or third parties once they have received my health information, images or recordings.
- 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.

**Signature of Patient only:** _____ **Date:** _____ **Time:** _____
**(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 checked my relationship to the patient below:**

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

**Representative's Signature:** _____ **Date:** _____ **Time:** _____
**(Required)**

**Address:** _____ **Phone:** _____

**You must attach proof of your authority to act on behalf of the patient as checked above (other than parent).**

**Internal Use Only: Revocation of Consent or Authorization for Disclosure of PHI**
Date:_____ Time: _____

Signature of Patient, Legal Representative, or Authorized Johns Hopkins Workforce Member receiving revocation request:

_____ _____
Signature Printed Name

Was written revocation sent by the Patient or their Legal Representative? If, so please attach to the original consent form. If written revocation involves *Images and Recordings* made for media release, please contact Corporate Communications and Media Relations at 5-6880.

## The Johns Hopkins Imaging and Recording Patient Information Guide

Please review this Information Guide before signing THE JOHNS HOPKINS CONSENT TO CREATE AND USE *IMAGES AND RECORDINGS* AND AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION on the front of this form.

**Protecting your privacy:** Johns Hopkins is grateful to patients who are willing to allow us to create and use images and recordings so that we can improve the care we provide. 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. Images or recordings taken as part of your treatment, identification or diagnosis, are included in your medical record and do not require consent; for instance, a picture taken of the inside of your stomach during an endoscopy or a picture of a rash being evaluated by a dermatologist. At all other times, your consent is required to make or use your images and recordings, and when authorized by you, to provide other personal information about your hospitalization and treatment.

- During the creation of images and recordings, your privacy is protected as much as possible. Whenever possible the images and recordings will be modified so that you are not recognizable.
- The Johns Hopkins staff will explain any intended use of the images or recordings so that all of your questions are answered.
- Images and recordings may include, but are not limited to, photographs, drawings, video or audio recordings, digital or electronic images, motion pictures, or other images.

1. **Images and Recordings for internal Johns Hopkins use:** These images and recordings are most often made for the purposes of quality improvement and education to improve patient care and recovery. For example, quality improvement use may include video monitoring of the time staff take to wash their hands prior to surgery to decrease the risk of infection and assure staff compliance with care standards. It may also include evaluation of the care and teamwork of staff treating a trauma patient in the emergency room. Internal educational uses may include the proper way to treat a wound, insert an IV, perform a procedure, or recognize a rare disease. Other internal uses may include research and will be written on the consent form.

2. **De-identified Images and Recordings:** These images and recordings are made, edited or altered so that you are not recognizable. An example might include a picture of a patient's arm with a new cast on it. These de-identified images and recordings may be used with your consent, within Johns Hopkins or externally outside of Johns Hopkins. External uses are those that will be seen by non-Johns Hopkins persons or the public and include, but are not limited to:

- Educational activities such as seminars, video conferencing, or training of non-Hopkins clinical staff.
- Printed and electronic publications such as textbooks, journal articles, CDs, DVDs, electronic media, podcasts, portals, motion pictures, channels or websites, such as Facebook or You Tube.
- Publicity, fundraising, media research or other external purposes as listed on the attached consent.

3. **Identifiable Images and Recordings:** These images and recordings are made so that you may be recognizable. For instance, a network may want to film a TV show about your care and treatment, or Johns Hopkins may want to use a photograph of you for an advertisement. Because you are potentially recognizable or identifiable, we require your consent to create and release the images and recordings, and your authorization to share any of your protected health information related to the images and recordings.

At times non-Johns Hopkins persons may be used to make images and recordings. For instance, a professional photographer, visiting professor, consultant, public news media personnel, or other third party not directly affiliated with Johns Hopkins. You will be notified if someone other than a Johns Hopkins employee will be making the images and recordings and your authorization for sharing of any of your protected health information will be required.
If you have any concerns at the time an image or recording is being made, the staff will be available to assist you, and answer any questions. We appreciate your assistance, and value your participation in helping us to improve the care we provide.