JOHNS HOPKINS
MEDICINE
THE JOHNS HOPKINS HOSPITAL

OUTPATIENT AGREEMENT FORM

Patient Identification Information

The Johns Hopkins Photographs, Audio and Video Recordings (PAVR) Patient Information Guide:

Internal Education and Quality Improvement

Please review this Information Guide before signing the **Photographs, Audio and Video Recordings (PAVR)** consent portion of The Johns Hopkins Inpatient or Outpatient Agreement form. **Photographs, video, and audio recordings (PAVR)** created and used at Johns Hopkins for the purposes of internal quality improvement and education are designed to improve patient care. Examples of how PAVR may be used include:

- **Quality Improvement Use- Video monitoring preparation the patient for surgery to prevent infection and ensure compliance with standards of care.**
- **Internal Education- The proper way to treat a wound, insert an IV or perform a procedure.**

Protecting your privacy: Johns Hopkins is grateful to patients who are willing to allow us to create and use **PAVR** so that we can improve the care we provide. At the same time, the privacy of patients, as well as the confidentiality of medical and related information, are among our highest priorities

- During the creation of PAVR, your privacy is protected as much as possible, and whenever possible the PAVR will be modified so that you are not recognizable.
- The Johns Hopkins staff will explain any intended use of the PAVR and answer any questions you may have.
- Use of your PAVR for purposes other than internal education and quality improvement shall require your additional consent and/or authorization.
- PAVR may include, but is not limited to photographs, drawings, video or audio recordings, digital or electronic images, motion pictures or other images

It is important that you **understand your rights** when PAVR is created or used. Your rights include:

- Consent for the creation and use of PAVR is voluntary. Your treatment will not be impacted, based on whether you sign the consent or not.
- Your consent will end only when the use of your information is no longer needed for the purposes of internal education and/or quality improvement.
- You may verbally request cessation of the creation of PAVR at any time while it is being made.
- You hereby release and waive all claims for compensation and rights to the images and recordings for which you consent.
- Following the creation of images and recordings you may revoke or withdraw your consent by mailing or faxing your written request to the care provider, clinic or department where your consent was made or given or to the Health Information Department. This withdrawal would affect only any new use of your PAVR by Johns Hopkins. If all identifiers have been removed from the PAVR this may not be feasible.

Please be sure to ask a Johns Hopkins staff member to clarify any questions you may have. We appreciate your assistance, and value your participation.

AUTH TO DISCUSS HEALTH INFO

JOHNS HOPKINS INSTITUTIONS

STANDING AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS

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)

For this Authorization, "**My Health Care Provider**" means ______________________________
(Name of Facility, Specific Physician or Provider, or etc.)

For this Authorization, "**My Health Information**" means any and all information relating to my course of examination and treatment.

If I have initialed here (________), "My Health Information" includes Substance Abuse Records/Information.

If I have initialed here (________), "My Health Information" includes Behavioral Health Records/Information.

I authorize My Health Care Provider to discuss **My Health Information** with the person(s) or entity identified below for general information and inquiries, arranging appointments, identifying medications, discussing billing and payment and any other related matter.

Name: ______________________ Name: ______________________

Relationship: ______________________ Relationship: ______________________

Phone #: ______________________ Phone #: ______________________

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, My Health Care Provider will not disclose My Health Information as requested.
- This Authorization is valid until __________ (not to exceed 1 year in Maryland), unless I revoke/withdraw this Authorization. If no date is included in the blank, this Authorization will expire one year after the date it is signed. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the department or office where my Authorization was made or given.
- 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, behavioral 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, ______________________________, **am the** (**check which applies**)
(print your name)

- ☐ **Parent with Parental Rights** *(applies only to minors) (not sufficient for substance abuse records)*
- ☐ **Informal Kinship Care Relative** *(applies only to minors) (Maryland only) (not sufficient for substance abuse records)*
- ☐ **Legal Guardian**
- ☐ **Patient/Plan Member Appointed Decision Maker** *(e.g., power of attorney) (not sufficient for substance abuse records)*
- ☐ **Default Substitute Decision Maker** *(e.g., surrogate, proxy) (not sufficient for behavioral health/substance abuse records)*
- ☐ **Court Appointed Personal Representative of Deceased, Executor or Administrator**

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).

JOHNS HOPKINS INSTITUTIONS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Johns Hopkins Notice of Privacy Practices.

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

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

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

Signature of Patient Only: ___________________________________ **Date**: ______/______/______
(Required)

If you are NOT the patient but are signing on behalf of the patient complete the following:

I, ________________________________, **confirm that I am the representative for the patient based**
(insert your name)
on the following relationship to the patient:

____
(state relationship, for example – parent, spouse, guardian)

Representative's Signature: ________________________________ **Date**: ______/______/______
(Required)

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

____
(city) (state) (zip code)