

**Authorization to Allow Access
to Information in The Alan Mason Chesney
Medical Archives**

I have been asked to give my consent to allow researchers to access materials in the Alan Mason Chesney Medical Archives (the "Archives") that contain health information or other private information about me. By signing this form, I give my consent to the access as described in this form.

1. **Describe the types of information to be used and disclosed by the researcher.** *(For example, "medical records from Johns Hopkins Hospital" or "physician notes of Dr. X for 1974"):*

2. **What is the purpose of the research activity? How will the information be used?**

3. **Give the names of anyone who will be given access to the information:**

4. **Give the names of anyone with whom the researchers may share the information and for what purpose:** _____

5. **By authorizing disclosure of the information, I acknowledge that, while the researcher will make every effort to assure that the information is used only for the purpose of the research activity, there is a risk of re-disclosure whenever information is disclosed and that, once my information is disclosed, it may no longer be protected by federal and state privacy laws.**
6. **I understand that I am not required to sign this form and that no care or other activity at Johns Hopkins will be affected if I do not sign this form.**
7. **I understand that this authorization has no end date, but that I may cancel the authorization at any time. If I cancel this authorization, the cancellation will only affect future use and disclosure of my information. Beginning on the date the authorization ends, no new health information will be used, but any health information that was shared before the cancellation will continue to be used.**
8. **I will receive a copy of this form.**

Signature

Date

Please type or print your name

If a personal representative, list authority for the person