Instructions

Second Opinion Request Form

Please complete as follows:

1. The first section of this form contains the necessary patient information.
2. Section 2 should be completed by your physician, should you want us to bill your insurance.
    a. Insurance and Medicare will not pay for 2nd opinions at the request of the patient.
    b. We do not accept Medicaid from states other than Maryland.
3. Section 3 must be completed so that your insurance may be billed.
4. The last page is a HIPAA release form, required for us to provide you with a copy of your report.
5. Self-pay patients, complete and print section 1, the HIPAA form and send along with your pathology slides.
6. For consultations billed to insurance, complete and print Sections 1, 2, 3 and the HIPAA form.

JOHNS HOPKINS
MEDICINE
PATHOLOGY

Patient Information – Section 1

Patient request for a pathology consult, self-pay;
Complete Section 1, to pay by credit card, call 410-933-1306.

To have charges billed to your insurance, the request for consultation must be made by your physician. Ask your physician to complete Sections 2 and 3, and submit the documents with the glass slides.

The cost of a second opinion from Johns Hopkins may be covered by your insurance. If you have an HMO *or* preferred provider organization (PPO) coverage, *you will need an authorization to have a second opinion done by Johns Hopkins University Reference Laboratories.* Medicare will cover a second opinion requested by a physician along with a medical reason why it was sent for a consult. ***Note:*** *patient and/or insurance provider may be contacted.*

Patient's Name: ____

Address: ____

Address: ____

City: ______________________________ State: ___ Zip: ____________

Phone: ____________________ Cell #: __________________________

Date of Birth: ______________ Social Security #________________________

Gender: Male Female Email ______________________________

Patient's Reason for consult:

Patient's Specific Questions:

Would you like a copy of this report sent to your physician? Yes no

Physician's Name____

last name, first name title

Address____

Address____

City_______________________ State ____ Zipcode___________

JHML PATHOLOGY CONSULTATION

To have charges billed to insurance this form must be completed by your physician.

Section 2

Consult requested by Clinician

Physician Name ____ NPI# ______________

Address ____

Address ____

City ________________________ State ____ Country __________________ Zip __________

Phone_____________Fax _____________ Email _______________________

Patient's Name ____Date of birth_____________

Patient's clinical history:

Reason for consultation / specific questions (required)

To verify the diagnosis and or grade for treatment purposes.

To resolve an equivocal diagnosis for treatment purposes.

To resolve a clinical-pathological discrepancy for treatment purposes.

Other

Working diagnosis:

Requesting Physician signature_______________________________________ Date ___________

MATERIAL SUBMITTED: specify case numbers

Total number of slides: Case number/s

Total number of blocks: Case number/s

Other material:

Which material needs to be returned to you? all none

Recuts (may be retained by JHML)? yes no

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Insurance Information - Section 3

Name of Patient: ____

Name of Insured: ____

Relationship to Patient: ____________________ Date of Birth of Insured:___________________________

(If address of insured is different than the patient's address, please provide here)

Insured Address: ____

Insured Address: ____

Insured City: ____________________________ State ____ Country _____________Zip ___________

Primary Insurance

Insurance Company Name ____

Insurance Company Phone ____________________ Insurance Company Fax ___________________

Group Number ______________________

Policy Number ______________________

Effective Date _____________________

Insurance Company Address (on back of card) ____

____

Insurance City _____________________ State ____ Country ________________ Zip __________

Secondary Insurance

Insurance Company Name ____

Insurance Company Phone _____________________ Insurance Company Fax ___________________

Group Number ___________________________

Policy Number ___________________________

Effective Date ____________________________

Insurance Company Address (on back of card) ____

____

Insurance City _______________________ State ____ Country ________________ Zip __________

JOHNS HOPKINS INSTITUTIONS

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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)

WHO

I hereby authorize ____to take the following action.
(name of Johns Hopkins health care provider)

ACTION REQUESTED (check one)

☐ Provide a copy of **My Health Information** to me ☐ Let me look at **My Health Information** (I am not requesting a copy)

☐ Release **My Health Information** to: ☐ Discuss **My Health Information** with: ☐ Obtain copies of **My Health Information** from:

____
(name of other person or entity)

____
(street address) (city)

____________________ ____________________ ____________________
(state) (zip code) (fax number)
(We cannot call before faxing.)

WHAT

For this Authorization, **"My Health Information"** means (provide description of health information desired):

____

____

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

If I have initialed here (________), this Authorization does NOT include records from other healthcare providers that are a part of my Johns Hopkins records included in this request. (If this blank is not initialed, those records ***will be*** included.)

For the date(s) of service from: _______________ to _______________ (records will be provided for all service dates if left blank)
(insert date(s) of service requested) (Note: Information from recent visits may not yet appear in the record.)

WHY

☐ At my request ☐ For my healthcare / treatment ☐ For legal purposes ☐ For payment / insurance purposes

Other: ____

FORMAT: I request that the copy be provided (where possible/available):

☐ on paper ☐ electronically on CD ☐ electronically on flash drive

☐ through a web portal, with notice provided to my email account at: ______________________________________

☐ by unencrypted e-mail to this email address: ____

☐ by other electronic means (if agreed upon by JH records department): ____

Important: I understand that the CD/disc or flash drive is not encrypted or password protected and that it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device. Additionally, I understand that unencrypted e-mail is not secure – that means it could be intercepted and seen by others; in addition, I understand that there are other risks with unencrypted e-mail including misaddressed/misdirected messages; e-mail accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. By choosing to receive **My Health Information** on a CD/disc, flash drive or by unencrypted e-mail, I am acknowledging and accepting these risks.

I understand there may be a fee for a copy of My Health Information. I understand that all fees will be in compliance with applicable law. I agree to pay this fee.

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here: _______________. 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 clinic or department 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, 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, please complete below

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

☐ **Parent with Parental Rights** *(not sufficient for substance abuse records)*
☐ **Registered Kinship Care Relative** *(not sufficient for substance abuse records)*
☐ **Court Appointed Guardian**
☐ **Legally Appointed Healthcare Agent** *(not sufficient for substance abuse records)*
☐ **Medical Power of Attorney** *(not sufficient for substance abuse records)*
☐ **Power of Attorney with Right to See Medical Records** *(not sufficient for substance abuse records)*
☐ **Surrogate Decision Maker** *(not sufficient for substance abuse records or mental health records)*
☐ **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 checked above (other than parent).