Name Pt# (MRN) Date of Birth	VCU Health VCU Medical Center Richmond, Virginia **Case Study Authorization**

CASE REPORT: Case description of _____
(disease or condition)

AUTHOR/CO-AUTHOR: Physician Name 1 _____

Physician Name 2 _____

The case report named above may be performed only by using personal information relating to your health. The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to control the use and disclosure of your medical information. Therefore, by signing this form, you specifically authorize your medical information to be used or disclosed as described below.

Use of your personal information

The following personal information, considered "Protected Health Information" (PHI) is needed to conduct this case report and may include, but is not limited to: name, address, telephone number, date of birth, government-issued identification number, and medical records and charts, including the results of all tests and procedures performed and to be performed in the future prior to the publication of the case report. Additionally, PHI may be shared with individuals designated to assist in conducting this case study as well as with accreditation bodies. PHI may also be reviewed to ensure that the case study meets legal and institutional standards.

Disclosure of your personal information

The main reason for sharing this information is to be able to conduct a case study and present or publish the results. The results of the case study may be published in one or more publications. Although information obtained from your medical record and chart will be disclosed in the publication, we will not publish identifiers such as your name, address, telephone number or government-issued identification number. Identifiers may be used, however, for sharing information with an agency authorized to receive reports on adverse events or situations that may help prevent placing other individuals at risk.

I hereby give authorization for the use or disclosure of my personal information for the case report based on my understanding of the following:

- I understand that you may use my personal information to prepare this report. The scope of the report, however, is limited to the case description indicated above.
- I understand that medical information that includes direct identifiers may be shared for the purpose of legal and institutional review as well as for the purpose of review by an accreditation body.
- I understand that the authorization to use my personal information to conduct this case report will expire at the end of the study. However, I understand that following publication, full articles or abstracts of or from the initial report may be published and continue to be published for an indefinite period of time.
- I understand that this authorization does not authorize the use or disclosure of personal information created or obtained after initial publication.
- I understand that I do not need to sign this authorization in order to receive health care.
- I understand that I may revoke this authorization at any time. However, the revocation will not apply to information that has already been released in response to this authorization.
- I agree that my personal health information may be used for the purposes described in this form.

_____	_____	_____	_____
Patient Signature	**Printed Name**	Date	Time

Interpreter (if used): Name/Cyracom # _____ Date _____ Time _____

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