**Authorization to Use and Share Protected Health Information for Case Reports**

We are asking you to allow SIU Medicine to use and share information about your ***[insert condition/disease/experience]*** for a case report. ***[Insert provider’s name]***, a provider involved in your care, would like to submit the case report to ***[insert medical journal name or institution name]***.

SIU Medicine would like to use certain protected health information to conduct this case report. The primary purpose for conducting and sharing a case report is to inform and educate other healthcare providers. The case report may be published for others to read (in print and/or online) and/or presented at a conference.

SIU Medicine is obligated to protect your privacy and not disclose your personal information without your authorization. When the case report is published or presented, your identity will not be disclosed. Although information obtained from your medical record will be disclosed, SIU Medicine will not publish or present any identifiers such as your name, date of birth, address, or telephone number. If you have shared your medical story, people who know you may be able to tell who you are from the information contained in the case report.

This information may include, but is not limited to your name, date of birth, information about your condition and treatment, prior health history, photographs, laboratory results and procedures performed.

You do not have to agree to let us use your medical information. Your decision will not affect your being able to get care at SIU Medicine. Your signature below means that you have read the above information about this case report and have had a chance to ask questions to help you understand how your information will be used and you give permission to allow your information to be used in this case report.

If you have any questions please contact ***[name of provider or program director]*** at ***[phone number]***

Name of Case Report Proposed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this form, I understand that:

* SIU Medicine Health may use information from my medical record but will not publish or share my name, date of birth or contact information.
* This authorization is valid until the case report is submitted for publication or presentation.
* Following publication or presentation, full articles or abstracts of or from the initial case report may be published and continue to be published for an indefinite period of time
* SIU Medicine will not use this authorization to use or disclose personal information created or obtained after initial publication or presentation of the case report.
* I do not need to sign this authorization to obtain care at SIU Medicine.
* I may revoke this authorization at any time by contacting the provider named above. However, the revocation of this authorization will not affect any actions taken by SIU Medicine prior to the revocation.

I agree that my personal health information may be used for the purposes described in this authorization.

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Patient or Patient Representative Name Signature Date

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Relationship to patient if not patient