CONSENT FORM FOR CASE STUDY

Title of Case Study:	
Author/Presenter Name(s):	
Name of Covered Entity:	[Name of the medical institution where the patient's health information is being collected]
Department/Division:	
Author/Presenter Contact Information:	[Provide both e-mail and phone number]

INTRODUCTION

You are being asked to allow information about your hospital stay and/or related treatment of your condition to be used to write what is a called a case study. A case study is typically used to share new, unique information experienced by one patient during their clinical care with physicians and other health care professionals outside of the covered entity. A case study may be published (in print or electronic format) for others to read, and/or presented at a conference or other educational event.

WHAT WILL HAPPEN IF YOU AGREE TO BE PART OF THIS CASE STUDY?

Information from your medical record will be collected to write an academic report on your clinical presentation, course, and treatment. The health information requested for use in this case study includes the following:

- [Provide a bulleted list of the patient's health information to be used for the case study. This may include, for example, results of physical examination, medical history, lab tests, radiology images, specimen photos, operative reports, pathology reports, physician notes, or certain health information indicating or relating to a particular condition.]

The authors/presenters of the case study are obligated to protect your privacy and not disclose your personal information (e.g., name, date of birth, medical record number). When the case study is published and/or presented, your identity will not be disclosed. Any photos or images used in the case study will not contain any identifiable information about you.

Taking part in this case study is completely voluntary. You may choose not to take part, or you may change your mind at any time. However, once the case study is published and/or presented, it will not be possible for you to withdraw your consent. Your decision will not result in any penalty or loss of benefits to which you are entitled, including the quality of care you receive.

WHAT ARE THE POSSIBLE RISKS INVOLVED WITH THIS CASE STUDY?

Identifiable information that is not essential to the case study will not be included. However, there is a small risk associated with this case study that could result in a loss of confidentiality by virtue of your unique clinical presentation.

WHAT ARE THE POSSIBLE BENEFITS INVOLVED WITH THIS CASE STUDY?

You will not directly benefit from participating in this case study. However, the information that can be shared with other health care professionals may improve future patient care.

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Allowing your information to be used in this case study will not involve any additional costs to you. You will not receive any compensation for participation.

WHAT IF YOU HAVE QUESTIONS ABOUT THIS CASE STUDY?

You have the right to ask, and have answered, any questions you may have about this case study. If you have questions, complaints or concerns, you should contact the Author/Presenter listed on the first page of this document.

By signing this form, I acknowledge that:

- My health information identified in this document will be published and/or presented in a case study to individuals outside of [name of covered entity].
- The case study could be published in a journal, textbook, or other educational publication and be viewed by a worldwide audience (in any media – print or online).
- The case study could be presented at a conference or other educational event, and may include audio/video recording to promote future viewing opportunities.
- All efforts will be made to conceal my identity, but complete anonymity cannot be guaranteed. It is possible that somebody, somewhere – perhaps, for example, someone who looked after me/my child/relative in the hospital/clinic, or a relative/friend – may identify me.
- My participation in this case study is completely voluntary, and my consent or refusal to participate will not affect my medical care in any way.
- I can withdraw my consent at any time before publication and/or presentation, but once my information has been committed to publication and/or presentation it will not be possible to withdraw my consent. If I wish to withdraw my consent after signing this form, I will contact the Author/Presenter listed on the first page of this document.
- A copy of this signed consent form will be provided to me for my records.

Signature of patient or patient's personal representative	Date
Printed name of patient or patient's personal representative *(e.g., patient is a minor, incapacitated, deceased)*	If applicable, a description of the personal representative's authority to sign for the patient