HIPAA AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR A CASE STUDY

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.

If you sign this document, you give permission to [name of specific health care provider(s)] at [name of covered entity] to use or disclose (release) your protected health information (e.g., health information about you that contains identifiers) for the case study listed below:

- [Specify the title of the case study]

The health information that we may use or disclose (release) for this case study includes the following:

- [Using a bulleted list, describe the **health information and the HIPAA identifiers** to be collected 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.]

[Name of covered entity] is required by law to protect your health information. By signing this document, you authorize [name of covered entity] to use and/or disclose (release) your health information for this case study. However, once your health information is released (e.g., via publication and/or presentation of the case study), your health information may be released or re-released without your permission, if permitted by law.

Please note the following:

- [Name of covered entity] may not condition (withhold or refuse) treating you on whether you sign this Authorization.

- You may change your mind and revoke (take back) this Authorization at any time, except to the extent that [name of covered entity] has already acted based on this Authorization. To revoke this Authorization, you must write to: [name of the covered entity and contact information].

- This Authorization does not have an expiration date [or as appropriate, insert expiration date or event].

- A copy of this signed Authorization will be provided to you for your records.

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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