**Authorization for Medical Case Study and publication**

**De-Identified Medical Information**

***Purpose of Authorization***

**Patient authorization is not usually required for case studies since they use de-identified patient
 health information. some medical journals are now requiring some type of authorization by the
 patient. This authorization may be used when the journal requires the author obtain the patient’s
 permission for use of the information for the case study. This authorization cannot be used if the
 diagnosis is such that it could reasonable be used to identify the patient (for example a rare disease)
 This authorization may be obtained by having the patient sign this document, or verbally, depending
 on the requirements of the publisher**

Patient Name: Mailing address:

 City: \_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1.** **Trinity Health of New York Entities**

I consent to and SJH Hospital, and SJH Med-PC [Professional Contract] site (including physician Professional Service Agreement [PSA] clinical office sites) research studies (clinical trial & non-clinical trial research studies)to use my health information for a medical case study. Only diagnosis and demographic information such as age, sex and race will be used in any published case study. All other medical identifiers will be removed and not use in the case study.

**2.** **Nature AND Purpose of Disclosure**

The nature of my health information to be used is diagnosis, care, disease progression, and treatment. I understand the case study will focus on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. There will be no patient identifiers in the case study and my name will not be used. I understand the case study will be used and/or published for medical education purposes.

**3.** **Re-disclosure**

I understand that once the case study is published Trinity Health New York does not retain control over its editing or use.

**4. Refusal to Authorize Use and/or Disclosure**

I understand that my refusal to authorize the use of my health information for the medical case study will in no way affect my eligibility to receive medical care at any Trinity Health New York care facility.

**5. Patient Compensation**

I understand that this is voluntary and that I will receive no compensation for the use of my health information for this case study or its publication. I further understand that I will have no economic and/or intellectual property right, title or interest, or any other property right or license in the case study authorized above.

**6. Trinity Health of New York Compensation**

I understand that Trinity Health New York will not receive financial compensation from a third party for the case study.

 Signature of Patient (or Patient’s Representative) Date

 Description of Authority to Act for Patient

Verbal Authorization Obtained \_\_\_\_\_\_\_\_Yes Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Trinity Health New York employee obtaining verbal authorization\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_