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 REASONABLY BE USED TO IDENTIFY THE PATIENT (FOR EXAMPLE A RARE DISEASE). THIS AUTHORIZATION MAY BE OBTAINED BY HAVING THE PATIENT SIGN THIS DOCUMENT.

Patient Name: _____ Mailing address: _____

City: _____State:_____ Phone: _____ DOB_____

1. **CONSENT**
   I consent to and authorize Rocky Vista University and its researchers: _____
   Student and Faculty/Preceptor Names
   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 used 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. 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 Rocky Vista University 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 health 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. **ROCKY VISTA UNIVERSITY COMPENSATION**
   I understand that Rocky Vista University will not receive financial compensation from a third party for the case study.

_____ _____
Signature of Patient (or Patient's Legal Representative) Date

_____
Description of Authority to Act for Patient

Name of Rocky Vista University Student or Faculty/Preceptor Obtaining

Authorization_____