Saint Agnes Medical Center

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: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

1. **TRINITY HEALTH OF FRESNO ENTITIES**
I consent to Saint Agnes Medical Center [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 Saint Agnes Medical Center 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 Saint Agnes Medical Center 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 FRESNO COMPENSATION**
I understand that Saint Agnes Medical Center 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: _____ Date_____

Name of Saint Agnes Medical Center employee obtaining verbal authorization: _____