COLUMBIA
COLUMBIA UNIVERSITY
IRVING MEDICAL CENTER

COLUMBIA UNIVERSITY IRVING MEDICAL CENTER
CASE REPORT AUTHORIZATION

I have been asked to permit the use of my medical information for a case report that may be submitted for publication or presentation at a conference. The medical information used in the case report will not include my name or any other information that will intentionally identify me. The information will be used for educational purposes within Columbia University Irving Medical Center (the "Medical Center") or for certain medical educational purposes, at national meetings of other treatment providers or for publication.

Health information for which I am authorizing use and disclosure includes:

☐ medical history ☐ images ☐ surgical information

☐ other _____

Federal privacy law requires that I review and sign an authorization before the Medical Center may use or disclose my protected health information for the above described purposes. I understand that once my information is disclosed the privacy laws may no longer protect it from re-disclosure.

By reviewing and signing this Authorization, I grant to the Medical Center, and to any persons or entities authorized by the Medical Center, the right to use, simulate and disclose my health information in connection with this case report. I release and discharge the Medical Center and their faculty from any and all claims, demands or causes of action that I may now have or may hereafter have for libel, defamation, invasion of privacy or right of publicity, infringement of copyright or violation of any other right of my or relating to any such use of my medical information in connection with the publication of this case report.

I agree that this Authorization contains the entire agreement and understanding between the Medical Center and me regarding this subject.

I UNDERSTAND THAT MY TREATMENT WILL NOT BE CONDITIONED ON MY SIGNING OR REFUSING TO SIGN THIS AUTHORIZATION. I MAY REFUSE TO SIGN THIS AUTHORIZATION. IF I REFUSE TO SIGN THIS AUTHORIZATION MY INFORMATION WILL NOT BE USED.

This Authorization does not have an expiration date. I have a right to receive a copy of this Authorization.

I may revoke this Authorization at any time. My revocation must be in writing and sent or delivered to the following address: Attn: Chief Privacy Officer, Office for HIPAA Compliance, Columbia University Medical Center, 630 West 168th Street, Mail Box 159, New York, NY 10032. My revocation will be effective upon receipt.

Patient Name _____ Date _____
(Please print)

Signature _____
Patient/ Legally Authorized Representative

Provider Name/Program/Department _____

Revised: February 2019