# INDIANA UNIVERSITY CONSENT AND AUTHORIZATION FOR CASE STUDY

You are being asked to allow use of your health information for a case study. The purpose of a case study is to share information about a unique medical problem to help other doctors and healthcare professionals. It is possible this case study may be published in medical journals and/or presented at conferences.

We are asking for your permission to use information [and images] related to your [specify disease, condition, or treatment]. The information about you released and used for this case study will include [insert description or bulleted list of record that will be accessed or used]. [Specify ALL individuals who will access information to prepare case study, e.g., Drs. XXX and YYY] who are preparing the case study may receive and/or use this information.

If you agree to participate, you authorize the following to disclose your medical record information:

[list of entities from whom medical records will be obtained]

This information will be included in the case study along with demographic information, such as your age, sex, or race. Your name and other identifiers (e.g., date of birth, medical record number, etc.) and any images that directly identify you will not be included in the case study. Every effort will be made to keep your personal information confidential, but there is a risk of loss of confidentiality and/or privacy. We cannot guarantee absolute anonymity once the case study has been published or presented. It is possible that someone with knowledge of the unique circumstances surrounding your situation could identify you from the information and images included in the case study. Your personal information may be shared outside this case study if required by law and/or institutional policies, and these individuals or organizations may not be held to the same legal privacy standards as are doctors and hospitals.

There is no direct benefit to you for allowing us to use your information for this case study, but we hope that sharing this information will help others in the future.

After reviewing this form and having your questions answered, you may decide to sign this form and allow your health information to be used for this case study. Or, you may choose not to allow your information to be used. This decision is up to you. If you choose not to allow your information to be used or change your mind after signing this document, it will not affect your usual medical care or treatment or relationship with [insert appropriate entity (i.e., hospital, university)].

If you change your mind and decide to withdraw your authorization for use and disclosure of your protected health information, you must do so in writing by notifying [name and mailing or email address]. However, once this case study has been published or presented, it will not be possible to withdraw your authorization. Otherwise, this authorization remains valid until the case study is published or presented.

## PATIENT’S CONSENT AND AUTHORIZATION

In consideration of all of the above, I agree to allow my health information to be used for this case study. I will be given a copy of this document to keep for my records.

**Participant’s Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Participant’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_**

**Participant’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[FOR RESEARCH INVOLVING CHILDREN, USE THE FOLLOWNING SIGNATURE BLOCKS, AS APPLICABLE]**

**Printed Name of Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Parent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Parent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_**

**[If the child participant will NOT sign this document, REMOVE the child signature block below]**

**Printed Name of Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_**

**[FOR RESEARCH INVOLVING INDIVIDUALS LACKING CONSENT CAPACITY, USE THE FOLLOWING SIGNATURE BLOCK]**

**Research Participant’s Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Research Participant’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of LAR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(Legally authorized representative)*

**Signature of LAR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_**